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Clinical Lecture.

PULMONARY CONSUMPTION AS TREATED IN THE PHILADELPHIA POLYCLINIC.

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If it is once properly understood that, in the vast majority of cases, pulmonary consumption is a local disease, the nature of which is a low catarrhal inflammation of the alveolar spaces resulting from a want of physiological activity in the affected part, the treatment of this disease will become comparatively simplified. Strange to say, however, everything which is known to be capable of producing morbid phenomena in the human body has, one time or other, been held accountable for the causation of pulmonary phthisis; and it is needless to tell you that its treatment varied accordingly. Let us premise our remarks, therefore, by saying that it is a disease with an intense partiality for the apex of either lung; and the question which most naturally suggests itself is, why the apex is so susceptible to, and why the middle and lower portions of the lung surfaces are so free from it? Is this the result of chance, or is it a law with antecedents as plain as the phenomenon is regular? A correct solution of this important question will go a great way towards defining the true origin of this disease. While not at all wishing to be understood as offering an all-sufficient explanation of this difficulty, we are quite justified in holding that one of the most potent and direct causes for such a state of things lies in the manner in which the bronchial tubes enter and are arranged throughout the lungs. These structures conduct the air principally in a downward direction towards the base of the lungs—hence the lowest parts of the lungs expand first, then the middle, and, finally, towards the very end of inspiration the apices expand, if at all. It is our firm belief, deduced from many observations, that in most persons who—like clerks, telegraph-operators, tailors, shoemakers, etc.—lead a sedentary life, and who maintain a stooped position of their chests and shoulders, the apices never become fully inflated. Another reason why the lower parts of our lungs are inflated more than the apices is because we possess nearly one-fourth more lung surface than necessary to carry on the process of respiration; and, therefore, that part of the respiratory surface which is filled with the greatest facility, viz., the base, performs the work of the whole. Therefore both the structure and the function of our lungs conspire to diminish the activity of the apices and enhance that of the bases. We have already stated, that the chief factor in the production of pulmonary consumption is a physiological inactivity of the lung apex; and if this proposition is true, then it should follow that those persons in whom the apices are least developed should be most liable to this disease, and *vice versa*.

Not long ago we made an investigation into the nature of this problem,[1] and found that the abdominal was the original type of respiration among both sexes; that the costal type of the female developed through the influence of abdominal constriction produced by clothing; that when the female falls a victim to consumption, her costal movements are markedly diminished; and that the female is less liable to consumption than the male in

[1] An experimental inquiry into the chest movements of the Indian female.—*Therapeutic Gazette*, May, 1887.

civilized life. It can be furthermore said that, according to Waldenburg, the vital lung capacity in persons who lead a sedentary life—such as professional men, students, clerks, etc.—is smaller than those who follow an active calling—like sailors, recruits, etc.—and it is a well-known fact that the latter class is much less susceptible to this disease than the former. And, moreover, our American Indians, who are not confined on reservations, and who are free to obey their roaming instincts, are almost entirely exempt from pulmonary consumption, presumably because of the greater lung capacity which their active life entails on them.

All these facts tend to confirm the correctness of our fundamental proposition, at least this far, that increased lung capacity decreases the liability of consumption. We think, however, when this fact is coupled with the other fact, that the civilized female possesses a much smaller lung capacity than the male, and is still less liable to the disease than the male, it is quite obvious that it is not a large chest capacity, but a well developed apex capacity which insures immunity from the disease. Barring her greater apex capacity, there is no reason, so far as we are able to discern, why the female should be more exempt from consumption than the male. Indeed, everything, both in herself and in her surroundings, tends to increase her liability in this direction. She is the weaker of the two; she undergoes the enervating processes of gestation and of lactation; she leads a sedentary and inactive life; she is occupied within doors during the greatest part of her lifetime, and is therefore constantly exposed to causes which are known to produce the disease, and most of which make the male notoriously liable if he is exposed to them.

In the next place it is important to trace the pathological relation between apex inactivity and pulmonary consumption; or, in other words, we must ascertain how such a want in development prepares the apex for the onset of this disease. You are all aware that if any organ, like a muscle, for example, does not receive adequate physical exercise, it diminishes in size; its muscular elements and connective tissue framework shrink in consequence. Precisely the same thing may happen when any part of a lung is deprived of its needed exercise—that is, when it is not expanded as fully as it ought to be during the act of inspiration—the air cells begin to shrink and collapse. The shrinkage is due to a contraction of the connective tissue around the air-cells, and the small bronchial tubes, and when sufficiently pronounced it constricts the blood-vessels and interferes with the free circulation of the blood in that part of the lung, and congestion and a low state of catarrhal inflammation follow as a consequence. This whole condition is analogous to that which occurs in the acquired form of atelectasy, and we would especially commend to you the remarks of Prof. Rindfleisch on the subject Atelectasia, in his well-known work on Pathological Histology. In tracing this state of things farther, we find that the epithelial elements multiply and accumulate in the alveoli and produce what is known as infiltration. In this way one alveolus fills up after another, until a whole group, or a cluster of them, is involved. Such an accumulation of catarrhal products exerts a decided pressure on the surrounding pulmonary and bronchial capillaries, and the blood-supply and nourishment are gradually diminished and finally cut off from these infiltrated areas, which, in due course of time, become more or less isolated and circumscribed masses, which are prone to undergo a slow process of cheesy degeneration, if the morbid process continues.

Pathologically then we have to deal here with a local infiltration of, or an accumulation of catarrhal epithelium in the air cells, brought on by physiological inactivity of the affected area, which area is in the great majority of cases confined to either apex. Now, what is to be done in a therapeutic way? Clearly, there are here two very important indications. The first is to combat the local infiltration, and the second is to annihilate its cause. This is the method which has been pursued for some time in the hospital of this institution.

In regard to the first indication, we would say that we have here an inflammatory deposit differing, in principle, in no wise from a similar deposit in any other part of the body, and the dictates of common sense point out that that which is useful in the one condition is also useful in the other. We all know the inestimable value of counter irritation, and of passive motion in producing resorption of chronic inflammatory deposits in joints, muscular tissues, etc., as well as in the external surfaces; and in consonance with this view we apply hot flax-seed meal poultices, every day from morning until night, for a period of three or more weeks. In connection with the poultice we apply friction, iodine, etc. We are certain, from quite an extended experience, that these measures produce a powerful impression on the infiltration in question, and that they facilitate

resorption more markedly than any other means at our command.

In addition to the poultices, we use local or general massage, once or twice a day, as well as electricity. In these cases of constitutional lethargy these adjuvants have the happy effect of arousing the local and general cell activity, and are usually followed by an increased appetite. In connection with all these external applications—poultices, massage and electricity—we advise our patients to take plenty of fluid food, such as milk, etc. This should not be given to the extent of satiation, but at regular intervals—say half a glass or a teacupful every hour.

So much then for the principal means which we believe have the power of dispersing the infiltrated catarrhal products of the lung; and what can be done in the direction of counteracting the source of the disease? From what has already been said, it must be quite evident to you that any measure which improves the air capacity of the apices will accomplish the end in view. Among the most important measures which fulfil this indication directly are voluntary and forced breathing. The former should be practiced by taking deep and long inspirations at intervals of two hours or oftener throughout the whole day. The inspired air should be retained as long as it conveniently can be in order to give the fullest possible expansion to the whole lung surface. The latter mode of breathing consists in inhaling compressed and exhaling into rarified air, or the reverse. This method is the most important lung expander of all. It should be begun gradually—say twice a day for a week or two, then three times for one week longer, then four times, and finally allow the patient to spend most of his time in the use of this apparatus. The great difficulty here is the limited time which the compressed air is generally employed. We are convinced that the best results follow when its use is protracted.

Physical exercise is an important indirect method by which the lungs are expanded. Under these conditions more oxygen is consumed by the muscles of the body than during rest; hence more blood flows through the lungs in a given time, and a larger lung-surface is thrown into activity. Those parts of our lungs which are but rarely or never called into use now are thrown into a state of healthy expansion, and it is in this way that our whole respiratory apparatus is made to approach that condition which gives the savage, and those who pursue an active life, that freedom from consumption which we know is so common among them.

In carrying out this method of treatment, the following points should be borne in mind: first, no exercise should be carried to the extent of decided fatigue; second, whenever possible, the body and head should be erect, the shoulders thrown back, and the lungs thoroughly filled with each breath; and, third, sufficient food must be taken during the intervals. Among the most important measures to increase the lung capacity is that of pulmonary gymnastics, which should be carried out in accordance with the following directions: The arms, being used as levers, are brought as far backwards as possible, and on a level with the shoulders, during each inspiration, and brought together in front on the same level during each expiration. Another way is to bring the hands together above the head while inspiring, and gradually bring them down alongside the chest while expiring. When a deep inspiration is taken in accordance with either plan and held until the arms have gradually moved forwards or downwards, and even longer, the process of chest expansion is materially enhanced. All these movements may be facilitated by using dumb-bells or chest-weights, etc.

This, in connection with stimulant medicines and nutritious food, has been the general line of treatment pursued, both at the hospital here and in our private practice, for some time; and we commend it to your consideration, in the full belief that you will not be disappointed in its results.

—Two sons of Dr. T. A. West, recently elected City Physician of Knoxville, Tenn., and a third man, named Goodman, attacked Mr. James F. Rule, city editor of a local paper, on Sunday, January 29, as he was entering a church. The attack was made on account of a communication reflecting upon their father, which appeared in the Knoxville *Journal*. Pistols and knives were used, and one of the sons was fatally wounded. The Philadelphia *Ledger*, January 30, 1888, says that the circumstance which called out the newspaper article was the election, on Saturday, of Dr. T. A. West to be City Physician by the City Council. West is not a graduate of a medical college, and the Council had repealed an ordinance for the purpose of making him eligible. This act aroused the indignation of the regular physicians of the city and was denounced by the medical society. The article was written by a physician and contained very severe reflections upon Dr. West and the City Council.

COMMUNICATIONS.

PRIMARY UNION OF THE AXILLA AFTER EXSECTION OF ITS CONTENTS: ILLUSTRATED BY THREE CASES.

BY J. S. WIGHT, M.D.,

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The question of primary union of the axilla, after removal of its contents, has been one of interest to me for years. Under the ordinary methods of bringing the parts together, I have always failed to bring about such a desirable result. After studying the question from many points of view, I thought of the following plan of bringing the wound surfaces in more complete apposition: A long, curved needle is armed with an aseptic silk suture. The needle is held by a strong pair of needle forceps. The point of the needle is inserted about one-half inch from the edge of the lower posterior flap, and carried under the entire bottom of the wound of operation, so that it will come out of the upper, anterior flap, also about one-half inch from its edge. The suture is completely buried in the tissues, so that it can nowhere be seen. From the lower anterior angle of the wound, going upward and backward, I insert five or six of these long, deep sutures. In some instances I have to let the needle come out near the bottom of the wound, and then re-insert it, finishing the complete introduction. This is necessary on account of the needle being shorter than the width of the wound. Now, as to the apex of the axilla: I use a catgut suture, and bury it in the tissues of the entire bottom of the wound. The needle is pushed up through the pectoral muscles, sometimes coming out quite near the clavicle, and it is then carried back, so as to take hold of the rest of the bottom tissues of the denuded surface, and finally brought out in the anterior flap, just opposite its point of insertion. The case may require two or three of these long and deep catgut sutures. When the sutures are all in place, the cut surfaces are carefully cleaned of any blood and kept as dry as possible by the use of aseptic sponges. The suture near the lower end of the wound is tied first, and then the rest are tied in the order of their insertion toward the apex of the axilla. The catgut sutures are tied last. Then the cut surfaces are brought entirely and completely into apposition, so that the blood ceases to ooze, and so that there is no cavity left for the accumulation of blood under any circumstances. The floor of the apex of the axilla is brought into contact with its roof, and is securely held there by the catgut sutures. The edges of the flaps may now be adjusted more accurately by a few small aseptic sutures, inserted by means of a small curved needle. To illustrate the working of this plan, I will put on record the following cases:

Case I.—October 14, 1886, I saw Miss R——, of New York, with Dr. McCorkle, her physician, to consider the advisability of removing some enlarged tubercular glands of the left axilla. On the 16th of October I operated, assisted by Dr. McCorkle, Dr. W. F. Dudley giving the ether. The glands were well supplied with blood vessels, which bled freely. They were ligated with catgut as they were cut. The sutures in this case were horse-hair and catgut. The horse-hair sutures were used for the part of the wound of operation in front, and were inserted as above described, the curved needle carrying them being made to take up a layer of tissue throughout the entire surface of the denuded structures. The walls of the axilla about the apex were completely brought into apposition by two catgut sutures. The blood clots had all been carefully picked out, and the oozing surfaces had been sponged clean. There was no cavity left to contain blood, and the cut surfaces were held face to face in their whole extent, so that they could not bleed. Some cotton wool was put in the armpit, and the arm was placed by the side, and held there by a roller bandage. The fore-arm was kept in a sling. The dressings were removed at the end of six days, when complete union had taken place. The stitches were removed; the catgut had been absorbed. There had not been any oozing from the wound. In this case the axillary artery was laid bare for about two and one-half inches.

Case II.—Mrs. B——, came to my office in May, 1887, having a large cancer of the left breast. It had been "drawn out" by a cancer doctor some ten months before. It had begun to ulcerate and bleed. I operated on the 30th of May, 1887, removing a very large mass from the left clavicle downward. At the same time I removed the entire contents of the left axilla, which contained enlarged glands and other abnormal tissue. In this case I did not use ligatures: The sutures, which were made of aseptic silk, were passed, as above described, through the entire surface of the operation wound, and performed

the office of ligatures, as well. Two catgut sutures were employed to approximate the floor and the roof of the apex of the axilla. The needle penetrated both the posterior and anterior walls of the axilla, coming out just below the clavicle, and being put in again close by, so that it could be carried back to a point not far from where it started. The armpit was dusted with iodoform powder, and filled with absorbent cotton, which was kept in place by a roller bandage. There was complete primary union of the entire axilla in four or five days; and the operation wound, in so far as the breast was concerned, also healed by primary union, except a small place near the clavicle, where the flaps could not be brought together.

Case III.—Miss A. C., aged 42 years, had a cancer of her left breast, which I removed October, 1887. December 7, 1887, I excised the contents of her left axilla, the glands beginning to enlarge. The hemorrhage was quite free, so that the hemostatic forceps were required for a short time; no ligatures were applied. Several aseptic silk sutures were put in on the plan above described; and two strong catgut sutures were put through the posterior wall of the axilla, and under a thin layer of tissue up to the apex of the axilla. They were both brought out just below the clavicle, and then were put in again close by, being carried downward through the pectoral muscles, and then out near the edge of the anterior flap. The clots were picked out of the wound of operation, and the surface was kept as dry as possible from oozing blood, so that the sutures, as they were tied, brought the clean-cut surfaces in contact. The catgut sutures brought the walls of the axilla near the arm and at the apex quite close together. The sutures acted as ligatures to the entire bleeding surface, as well as to the cut arteries. There was no cavity to contain blood left, nor was there any concealed bleeding. In this case, iodoform powder was dusted over the incision, after the insertion of a few co-aptation sutures, and some absorbent cotton was put in the armpit. The arm was bandaged to the side, and the fore-arm was put in a sling. Complete primary union took place in about a week.

The points involved in this plan of operation to get primary union of the axilla after removal of diseased tissues are simple, and are not difficult to put in practice.

First. Primary union requires that the fresh surfaces be put and kept in apposition, so that the new cells of the connective tissue may grow together as they form on both sides of a wound. The sutures, as I have put them into the walls of the operation wound in the case of exsection of the contents of the axilla above described, have accomplished this purpose.

Second. The thorough arrest of the flow of blood from cut blood-vessels and from oozing fresh surfaces of operation wounds is an important condition to promote the speedy formation of scar-tissue. The sutures, as employed in the above-described cases, accomplish these two objects in a practical and satisfactory manner.

Third. The soft aseptic compress in the armpit co-operates with these subjacent sutures in keeping the entire wound surfaces in apposition, and in arresting the flow of blood from the large cut vessels and from the oozing fresh surfaces.

The results of this plan of closing the axilla, when its contents have been removed, are very gratifying to the patient and very satisfactory to the surgeon. On the one hand, the patient is up and about in a few days, and requires only one or two dressings. On the other, the patient is not unfrequently kept for weeks with a profuse discharge from the axilla, and is annoyed by daily dressings of a painful operation wound, in which there is often severe inflammation. In order to obtain primary union of the axilla, the surgeon may require a little more time than he would occupy in operating for union by granulation. But this is only a trifle compared to the time taken to dress a suppurating axilla week after week.

Of course, there are conditions of the axilla in which it would be impossible to obtain primary union. But these conditions are somewhat exceptional. It seems to me that primary union may be obtained after the greater number of exsections of the contents of the axilla. When the general health is reasonably good, and when the wound-surface can be well freshened, and when the subjacent sutures are properly put in, and when the coaptation sutures are applied, primary union of the axilla will become the rule.

—The wife of Dr. Oliver Wendell Holmes died at her residence on Beacon street, Boston, on February 6, 1888, in the 69th year of her age. Mrs. Holmes was a daughter of Judge Charles Jackson, one of the Justices of the Supreme Judicial Court of Massachusetts, who sat on the bench from 1813 until 1824. His daughter was married to Dr. Holmes in June, 1840.

PECULIAR CASE OF STRANGULATED HERNIA; OPERATION; RECOVERY.

BY MONTGOMERY LINVILLE,
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Miss Lizzie S., about 26 years of age, had occasionally noticed an enlargement in the right groin for six years. As it always disappeared in a few hours, and gave her but little pain, she failed to consult a physician until May 2, 1887, when the tumor became so large and painful that she sent for me in great haste. I found her suffering with violent cramps and vomiting, caused by a large inguinal hernia on the right side. I succeeded in reducing it in a few minutes, and as it entered the outer ring there was a distinct snapping or tearing sound, which I could not account for at the time; but later developments fully explained it. I applied a suitable truss, and warned her of the danger of neglecting to wear it. As long as she followed my advice she had no trouble. About the middle of July she became careless, and neglected to wear the truss. The result was that she again sent for me to reduce the hernia; but my efforts were not attended with the same success as on the first occasion. I gave her a hypodermic injection of morphine to relieve pain and vomiting, hoping it would relax the parts sufficiently to enable me to succeed during my next visit. But this hope was vain. I then administered chloroform, and after repeated efforts succeeded in reducing the hernia to about one-half its original size. As this gave her considerable relief, I continued the hypodermic injections of morphine, and finally succeeded in reducing the hernia on the third day. I then explained to her the importance of always wearing her truss, and stated that if she neglected to wear it, sooner or later an operation would be necessary.

But once again she disregarded my advice, and about the middle of September, 1887, while moving a wash-stand, the hernia again came down; she went to bed, and for thirty-six hours made a heroic effort to reduce the hernia herself, as she was loath to send for me on account of her disobedience. But violent cramps and vomiting forced her to do so. On visiting her, I found the hernia much larger, and more tender and painful than on the previous occasions. I should have operated at once, but my former experience made me hope that I could reduce the mass, and caused me to delay until the third day. By this time her symptoms became so alarming that I was forced to operate, assisted by Drs. James Wallace and Joseph Cooper, of New Castle. I cut down to the sac and found it firmly adherent, and that it extended from the external abdominal ring obliquely to the crest of the ilium. I succeeded with difficulty in breaking up the adhesions; but I found the neck of the sac so firmly contracted with bands of adhesions, and in such an unhealthy condition—being almost black—that it would be necessary to excise it. I proceeded to open the sac, and for a few moments was horrified with the thought that I had made a mistake and cut open the bowel, for several dark colored semi-round bodies appeared, about the size of a plum, and resembling lumps of fecal matter; but, after a more careful examination, we discovered that they were lymphatic glands in a partially broken-down condition. Immediately under the glands I found the strangulated loop of bowel, and easily pushed it up into the abdominal cavity. The sac, and especially its neck, being in a very unhealthy condition, I excised it as high up as possible. But I could not remove all of the diseased portion, as there was evidence of a local peritonitis on the right side. There was very little hemorrhage, so I inserted a drainage tube and closed the wound with deep sutures, and applied an antiseptic dressing. I had but little hope that my patient would recover. Everything was against her: the delay in operating; a delicate constitution; the diseased condition of the sac; and especially the local peritonitis. But she did gradually recover, and eventually regained perfect health.

The after treatment consisted in keeping the patient under the influence of opium. Morphia, given hypodermically, seemed to agree with her best, and I gave large doses —half a grain three or four times every twenty-four hours, for the first week. I gradually reduced the dose during the second week, and discontinued it on the fifteenth day after the operation.

The fact that we found three lymphatic glands in the hernial sac is the most interesting part of this case. The query is, how did they get there? My theory is that they became firmly adherent to the peritoneum—the hernia being of long standing—when I first reduced the mass of intestine, which was four and a half months before the operation; the glands were torn from their natural attachments, and were forced up into the abdominal cavity with the peritoneum. This supposition would account for the peculiar snapping or tearing sound which I heard on that occasion. The next time the hernia came down, the peritoneum came first, then

the glands and the bowel; thus the peritoneum formed a regular pocket for those glands. They were in this position four and a half months, slowly breaking down. For some weeks before the operation the patient complained of soreness and pain in the right side, no doubt caused by a subacute local peritonitis. I have never met with, nor heard of, a similar case. For this reason, and because my patient recovered under the most unfavorable circumstances, I have consented to write this brief history of the case.

If any of the readers of the MEDICAL AND SURGICAL REPORTER have met with a similar case or cases, I would be glad to hear from them.

TREATMENT OF LAME BACK—LUMBAGO.

BY CLARENCE G. HOLLISTER, M.D.,
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About three years ago my attention was directed to the number of cases coming under my observation, in which men who were habitually exposed to all sorts of weather, and accustomed to laborous work, would come to me complaining of severe pain in the lumbar region, over the region of the kidneys, which was worse in the morning. Almost all my patients said that they did not put forth great effort on arising from bed in the morning, they could not have gotten up strength to start about their work. They all said also that the pain and lameness passed off to a certain extent as they were at work during the forenoon—although not entirely—only to recur on the following morning. Nearly all had a diagnosis ready for me, which was invariably: kidney disease. However, it seemed easy for me to diagnosticate muscular rheumatism. I had had two or three cases which had proved most stubborn, when the patient, whose case I will now describe, came to me for treatment. His case, which is a fair representation of others which followed, had extended over a period of two years, and his sufferings were so severe that I felt as if I must try some new combination of remedies.

The patient, H. E., male, about 45 years old, a cooper by trade, presenting the appearance of a hard-working and rather weak-looking man, came, almost creeping up into my office, and with his hand at his back, gradually settled down into a chair, and prefaced his request for treatment by informing me that he had suffered so with "kidney disease," or pain in his kidneys, that one-half of the time, during the past two years, he had been unable to work, and the other half he had been obliged to keep his young son at his shop to stoop for him and to hand him the necessary articles while he stood up and, with the greatest effort, made barrels to support his family. He had been under the care of many physicians, and as he was no better he was almost despairing. A careful examination did not reveal the least trouble in his kidneys, so I concluded the case was one of muscular rheumatism. In his treatment he had been given almost everything regularly known for such cases, and I therefore placed him upon the following prescription, without much confidence that it would relieve him:

℞ Potass. iodidi.....ʒss
Potas. bromidi.....ʒss
Tr. colchici sem.....fʒiss
Syr. aurantii cort.....fʒij
Aquæ..... ..... q.s. ad.fʒvi
M. Sig.—One teaspoonful three or four times a day, or increased, until the bowels are slightly acted upon.

I had no great hope of success with this prescription, as I had used the same ingredients in other combinations in a number of cases before. But I sent the man home with the instructions to report in about one week. At the end of this period he did report, and was able to walk quite comfortably to my office and let himself down into a chair less cautiously than before. The improvement was marked, and I advised him to continue using the medicine. After this the patient improved so fast that when he had taken three or four bottles he declared himself well; and now, for three years, he has not been laid up for one single day, and can do as big a day's work as ever. Once every three or four months he takes, of his own motion, a small bottle of the medicine, as a sort of preventive.

This case being well known in the community, not less than eighteen or twenty cases came to me during the following two or three years, all complaining in a like manner, though some cases were not as bad as this one. All of them had lasted over a year. Among the patients who followed the cooper was a locomotive fireman, who had made up his mind to abandon his engine because the pain and lameness in the muscles of his back were so bad, paper-hangers, a blacksmith, a few farmers, etc. All but two were relieved promptly by the above combination.

There is nothing new in the use of the remedies named above, but combining them in the manner stated was new to me. The striking feature of my experience is the

fact that cases of muscular rheumatism of the lumbar region, which are usually so tedious, were promptly relieved and remain relieved up to the present time. The consequence has been that the remedy became so well known that my druggist often spoke of putting it up in bulk and handing it out *ad libitum* to all persons suffering with lumbago. But the demand for it died out with the scarcity of cases, as about all the cases of this sort of "lame back" in this neighborhood had tried the remedy and were pretty well relieved.

In closing, I will say that no simple formula ever gave me such uniformly good results as the above did in the cases for which it was indicated.

HEMORRHAGE FROM HANDS AND FEET IN AN INFANT; PELVIC CELLULITIS IN THE MOTHER.

BY E. C. HELM, M.D.,
CHICAGO, ILL.

Early in November, 1887, Mrs. K. was confined, being attended by a midwife. On December 4, I was called to see the child, being told that it was "bleeding from the hands and feet." The mother was sitting up in bed, sweating profusely, and the midwife informed me that she was "convalescing from blood poisoning." Her previous history, I learned, had been that of fever on the third day, with scanty lochia and a small flow of milk, with some abdominal pain and uneasiness. She had been better the last few days; in fact was under charge of another physician when I was called in to see her child.

The child was very pale and bloodless. On removing the blood-stained bandages from its hands and feet, I observed that the blood transuded through the skin of the palms of the hands and the soles of the feet. The blood did not readily coagulate, and was very thin, resembling bright red serum. I ordered frequent astringent washes and powders, and nourishment to be given.

In a few hours I was summoned again, and found the palmar and plantar hemorrhage had ceased, but an abundant hematemesis taking place. The blood vomited was dark and thick. A few hours after this was checked, the palmar and plantar surfaces began to bleed again. I was unable to control the hemorrhage from the stomach, and hands and feet, at the same time, for longer than a few hours, as checking it at one place invariably caused a hemorrhage at the other.

The child died in forty-eight hours. The remedies used were ergot, aromatic sulphuric acid, internal and external astringents and plenty of food, but all were of no avail. The child either bleed internally or externally the greater part of the time, but never both at once. When the hemorrhage was external, it was always from all four of the surfaces mentioned, never from one or two of them.

The mother's condition had improved and the other physician was dismissed. About the middle of December, and six weeks after delivery, I was again called, and found the patient in bed, with high fever and great pain in the region of the uterus, especially on the left side. The uterus was immovable, the *cul-de-sac* of Douglas was full and tense, but showed no signs of fluctuation. The entire pelvis, especially to the left of the uterus, was filled with the exudate. Under treatment the woman rapidly improved for three weeks, when suddenly, two hours after I had seen her, she was taken with severe pain in the region of the left ovary, and it was several days before this pain was under control. The temperature, which for the last week had been nearly normal, jumped to 104°. There never was much tympanites. A hard, sensitive mass could be felt externally, and bimanual examinations showed it to be as large as a goose's egg. It appeared to be in the folds of, or just back of, the left broad ligament, probably the latter. This grew larger for two weeks, and then the patient informed me one day "that the lump was gone." Learning that there had been no discharge of pus, I was considerably puzzled. She said the urine had been rather thick, but she had thrown it away.

Securing a sample as soon as possible, I found, under the microscope, a few pus cells. The diagnosis of rupture into the bladder was now clear. In a few days the fullness and pain returned, but they soon subsided. This process was repeated ten or a dozen times, as the opening into the bladder was doubtless small, leading to frequent refillings and evacuations of the pus cavity. From this time the pus cavity became smaller and smaller, until, three months after pus was first discovered in the urine, the microscope occasionally failed to show pus; and in another month none whatever could be found. The tumor had disappeared, the uterus regained much of its mobility, and the patient was convalescent.

This case was very interesting to me, and so I send it to the REPORTER. As the child nursed the mother while she was suffering from blood poisoning, it has been my opinion

that its sickness and death were due to the poisoned milk; although I have never heard of a case having this peculiar variety of hemorrhage.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, January 25, 1888.

The President, J. Solis-Cohen, M.D., in the chair.

Dr. Edward Martin read a paper on

Ichthyol in Surgery.

Ichthyol was first described by Schrötter, and used in the treatment of skin diseases by Unna. It is obtained as a clear yellow-brown oil by distilling bituminous matter found in the Tyrol, and containing the fossilized remains of fishes and marine animals. By the action of sulphuric acid on this distillate, and subsequent neutralization with soda or ammonia, either the sodium or ammonium sulphichthyolate is produced. The latter compound is preferred by Unna. The ammonium sulphichthyolate is a reddish-brown, clear, syrup-like liquid of burning taste and odor, soluble in water, making a clear red-brown solution, and also soluble in equal parts of alcohol and ether. The ichthyol preparations are characterized chemically by their richness in sulphur (ten per cent.), so intimately united that it can only be extracted by complete decomposition (Lartigau); they easily take up oxygen, acting as powerful reducing agents (Baumann).

Clinically, the ichthyolates are described by Unna as being powerful antiphlogistics, causing anæmia and rapid subsidence of swelling in all tissues. This antiphlogistic effect is ascribed to the drug's action on the endothelium of the blood-vessels, depriving it of oxygen in virtue of its reducing properties, and contracting the lumen of the vessels. This explanation is not perhaps entirely satisfactory, but physiological studies have not yet given us a better one. The cornifying effect of the drug on the epithelium of the rete is undoubted.

Surgically, what are the indications for the drug? Lartigau states that it is indicated in all subcutaneous and inflammatory tumefactions, œdemas, vascular dilatations, incipient furuncles, and local manifestations of rheumatism.

Elliot praises it highly in burns of the first and second degree (five per cent. solutions in water), as producing rapid subsidence of pain and inflammatory symptoms. He finds its application to obstinate varicose ulcers associated with eczema rubrum (sodium compounds, three to five per cent.) at times productive of marvellous results. In his hands it is also useful in cicatrices, and in a few cases of rheumatism and neuralgia has given immediate and marked relief from pain. Schweninger states that in rheumatism, lumbago, ischias, tic, gout, and migraine, local applications of ichthyol act more powerfully in allaying the pain than any known medication. Lorenz is astonished at the fabulous efficacy of the drug. In acute and chronic joint-rheumatism, acute muscular rheumatism, mastitis, panaritis, and contusions, a few rubbings, with pure or fifty per cent. ichthyol compounds, are peculiarly successful in allaying pain and hastening healing. In chronic and acute joint-rheumatism relief often follows a single rubbing, while this is the rule in acute muscular rheumatism. The pain of gout disappears, the shining red skin becoming quickly wrinkled. A beginning mastitis or panaritis is always aborted, or if fully developed, the pain is much relieved. Its prompt use prevents the discoloration following contusions. It immediately allays the pain of a burn and prevents blistering. Finally, a ten per cent. solution hastens the cicatrization of badly-healing ulcers. Loring dilutes the drug with water when pure ichthyol compounds cannot be borne, and prevents irritation of the skin by careful washing and drying before each application.

Von Nussbaum states that a single application of ichthyol one part, water four parts, lanolin five parts, has allayed the itching of eczematous ulcers which had resisted all known applications for weeks and months, and promptly brought about rapid cicatrization on being continued a few days. Arthritic pains, which for weeks have made day and night miserable, are relieved at times in one-half minute after the application of a strong ichthyol ointment. In erysipelas it produces results obtainable by no other means, namely: the immediate arrest of the disease. Von Nussbaum's treatment was first the thorough disinfection and drainage of the wound, then, if the disease continued to extend, over its whole surface a thick layer of ichthyolate and vaseline, equal parts, was spread, and covered by a layer of ten per cent. salicylated cotton. The erysipelas advanced not a line further, and in a single

day the swelling disappeared, and the red, shining, puffy surface became yellow, brown, and wrinkled. This remarkable effect Von Nussbaum ascribes not to the influence of the drug on Fehleisen's cocci, but rather to a change produced in the tissues, by virtue of which they cease to favor the growth of the micro-organisms. Stelwagon has had excellent results in the abortion of furuncles by ichthyol preparations.

Agnew (D. Hayes) considers the ichthyol preparations more powerful than any known therapeutical agent in bringing about reduction of inflammatory enlargements, and has had particularly good results in recently enlarged lymphatics. He uses sulphichthyolate of ammonia and iodide of lead, equal parts, applied generously and covered in by oiled silk.

The writer has used ichthyol in: (1) Six cases of cervical adenitis, with absolutely no relief; cure being subsequently brought about by iodine or the knife. (2) Fifteen cases of marked inflammatory induration of the subcutaneous tissues, with invariably a speedy and in some cases almost magical reduction, and this after other means had been tried unsuccessfully. (3) In two cases of furuncles without good effect. (4) In one case of cellulitis without marked effect till the knife was used. (In this case staphylococci were found, but no chains.) (5) In four cases where pain was the most marked feature of inflammation, with complete relief in three and no effect in the fourth. (6) In one case of erysipelas of the scalp, with immediate cure. The latter is so striking that it is reported in full:

B. C., bartender, aged thirty-six, a full-blooded Irishman, was struck on the head by a bottle whilst intoxicated, December 20, 1887. Two slight wounds of the scalp were inflicted, to which no dressing was applied. On Dec. 22, the symptoms were chill, fever, nausea, great pain in the head, and swelling. He then went to a clinic; wounds were opened, disinfected, and catgut drainage provided; symptoms progressive. He was seen by the writer on the second day of his fever, the fourth from the infliction of the wound. He had had no sleep for two nights; the pulse was 106; temperature 103°; violent headache; whole scalp puffy, œdematous, and very tender; a few drops of thin pus were squeezed from the wounds. Cover-glass preparations of blood from puncture by tenotome showed Fehleisen's chains. A saline purge and iron were ordered internally. On the scalp was placed a thick layer of ammonium ichthyolate and vaseline, equal parts. The pain was relieved almost immediately; the patient slept comfortably; his temperature the following morning was 98°, and he was and remained well.

This is not different from the results obtained by Nussbaum. With the exception of the case of erysipelas, the writer used a ten per cent. ointment of ammonium ichthyolate in lanolin, fearing lest, in the case of stronger applications, his effects might be ascribed to counter-irritation. It is possible that stronger preparations would have proven efficacious in the treatment of cases of adenitis, in which the weak ointment signally failed. The extravagant praises bestowed by some authors on ichthyol savor more of proprietary advertisements than scientific contributions, and the variety of affections for which it is recommended might well make one doubtful as to its complete efficacy in any single instance.

An analysis of the cases in which it has proven serviceable will show, however, that they can be relegated to one of two classes: 1. Affections characterized by inflammatory enlargement. 2. Affections characterized by pain of peripheral origin, probably depending on inflammation or congestion.

For either of these conditions, theoretically, a powerful antiphlogistic would be indicated, so that the clinical indications for the use of the drug correspond to its alleged therapeutic effect. When the surface is irritated, weak solutions (three to five per cent.) should be used; but when the skin is intact and the subcutaneous tissues are to be affected, pure or one-half strength ointments give the best results. In using strong preparations the skin should be washed with soap and warm water, and thoroughly dried before each application. Ichthyolates can be combined with any of the ointments, or can be dissolved in water.

The writer's success with the drug, even where it was not used in the most efficient manner, has convinced him that the praise bestowed on it by the Germans is well merited. Where suppuration has actually taken place the weak ointment is not of service, but in the allaying of inflammatory pain and the resolution of subcutaneous induration (excepting adenitis) the results are most satisfactory.

Dr. A. J. Downes read a paper on

Some Interesting Sequelæ of a Case of Scarlet Fever, with Pathological Specimens.

On November 15, 1887, at 3 P. M., I was asked to see B. M., a boy of seven years, then under the care of a homœopathic practitioner, and said to be dying of heart disease. I called

immediately. The boy was comatose; had been so for twelve hours. The face had a characteristic pallor, the eyelids were slightly puffy, the pupils dilated, the breathing stertorous. I listened to the heart, and heard a loud systolic apex murmur, a diastolic one at the base, and mingling with both a peculiar whistling sound, the cause of which at the time I did not understand. Examining further, I found that the eyelids had become puffy two days previous, that the feet and ankles were now swollen, and the scrotum slightly so. No urine had been passed within twenty-four hours. Excepting a few scybala, forty-eight hours before, the bowels had not moved in seventy-two hours. The child had had scarlet fever five years before. I told the father that the boy did have heart disease, but that he was dying of uræmia. Shortly after 5 P. M. the boy was dead. The following morning Dr. Martin Rively and I made a post-mortem examination. The specimens I show are the heart, kidneys and a piece of the liver. So advanced cardiac lesions in a child of this age are far from common. The ventricles are both hypertrophied and the cavities dilated; the right considerably. The curtains of the mitral valve are thickened and fibrous, the posterior leaflet is exceedingly contracted, and shows above it a recent inflammatory area. The aortic curtains are a beautiful picture of an insufficient valve. The whistling sound I heard during life must have come from the tricuspid valve. The hypertrophy of the muscular elements of the ventricle, with the marked distention to which the cavity was subjected, surely allowed sufficient leakage to cause this sound.

On account of its so late recognition and its undoubted influence in enhancing the cardiac condition, the state of the kidneys is exceedingly interesting. Even macroscopically the kidneys show changes which must have been going on for some time. The pale cortex and the eversion of the cut edges indicate fat. Under the microscope we find evidence of long existing changes, sufficient to warrant the assumption that the kidney changes began in the long-ago attack of scarlet fever. The tubules are swollen, distorted and full of casts. The epithelial cells lining them are somewhat granular and smaller than normal, with their nuclei becoming indistinct. Long existing changes therefore exist. We find also recent conditions. The glomerules are swollen and congested, and in their vicinity an infiltration of small indifferent cells—a very characteristic glomerulo-nephritis of recent date—which was the cause in this case of anuria and consequent uræmia. And the history points to this; for the boy, although not well for a few years back, was comparatively so. For two weeks previous to his death he was confined to his bed, and undoubtedly during this time he was suffering from a glomerulo-nephritis, which, adding itself to an already damaged kidney, precipitated an attack of uræmia. Additional proof that the boy's kidneys were not normal prior to his last sickness is not wanting. His bladder, on post-mortem examination, was found to contain about two ounces of urine—the accumulation of twenty-four hours—of this I collected one ounce. It contained a large amount of albumin, but no sugar; round and columnar epithelial cells, showing fatty degeneration; a few epithelial casts containing oil globules and some free oil. A few weeks' nephritis could not cause this condition of the urine. The liver changes are secondary to the heart condition. Under the microscope it shows both fatty infiltration and degeneration.

In concluding, I would recall the points that interested me in the case. 1. The extensive cardiac lesions caused by scarlet fever occurring in a child under two years. 2. The late recognition of the heart affection; the non-recognition of the kidney condition. 3. The occurrence of acute inflammation—the glomerulo-nephritis almost typical of scarlet fever—in an already damaged kidney. Finally, may I not call attention to this case as showing to what extent the sequelæ of scarlet fever may advance when not recognized and treated. And the history of the past proves such to be the fact. Eight homœopaths in succession had charge of the boy for four years prior to his death. Over a year ago one had diagnosticated diabetes. The one in attendance before my visits had recognized valvular affection. But the kidney lesions had escaped them all. Apparently this proves that the case ran an almost natural course.

Dr. James Tyson exhibited

Fleischl's Polarizing Saccharimeter,

made by Reichert, of Vienna, and explained its use. The deviation is indicated by the displacement of a dark band continuous in two parallel spectra, when no glucose is interposed and the instrument reads 0. When a column of sugar is interposed a deflection takes place, and after the continuity is again restored the *percentage* of sugar is read off from the vernier.

Dr. Tyson said the polarizing saccharimeter could not be recommended for testing qualitatively very minute quantities of sugar, say anything less than one-half of one per cent.,

Fehling's solution being really more delicate. Nor can it be said that there is any saving of time in testing qualitatively solutions contain less than one per cent. The advantage of its use is shown in determining from day to day the quantity of glucose in specimens containing considerable amounts, where the requisite dilution and titration occupy much time. In very clear urines it is not necessary, with Fleischl's instrument, to decolorize with acetate of lead solutions, but where they are not almost colorless it is necessary to treat with basic acetate of lead in the proportion of 1 c. c. to 10 of urine and filter, when one-tenth should be added to the reading of the vernier.

In opening the discussion, Dr. L. Wolff said: The instrument to which Dr. Tyson referred, and which I had the honor to bring before you here, is known as a polarization microscope, though this is an improper term, as it is simply the utilization of the microscope stand for the adjustment of the parts of a polarizing saccharimeter. I imported the parts constituting this about a year ago from the manufacturer, Paul Waechter, of Berlin. Its principal advantage is that of price, which, to the best of my recollection, is about twenty-five dollars when bought here. Like all other saccharimeters it consists of a polarizer which, as you see, is attached to the substage; on the top of this fits a plate consisting of two demi-disks of quartz of opposite rotary power, which let the intersecting line be readily seen through the analyzer. This latter, with the vernier and nomus, fits into the microscope instead of the draw-tube. The analyzer or scale can be so adjusted that when the nomus points to 0° the two semi-disks will be of an even neutral violet tint. In this position it is fixed with a screw. The tube is then withdrawn and the glass container with the urine is screwed in, when the whole is replaced. In looking through the instrument it will now be seen that the two semi-disks are no longer of neutral tint, but one is red and the other blue. On the rotation this inequality of color will disappear at a certain point, and when the neutral violet tints are again seen, the angle is read off. With this angle you can refer to the accompanying table and read off the amount of sugar present in grains contained in one litre, or by dividing this by ten the percentage will be arrived at. I have used this little instrument a great many times and find that it is quite as accurate as the larger and more expensive apparatus.

It is my custom to make about six readings, which is very rapidly accomplished, and take the mean thereof by dividing the sum of the readings by six. With some practice and an eye trained for color, the results come generally within one-tenth of one per cent. of the amount of sugar present. Like every other instrument, it requires practice to get good and accurate results. While for those who have to make many quantitative determinations of sugar in urine, the polarizing saccharimeter offers great advantages, I quite agree with Dr. Tyson that, for single and isolated determinations, Fehling's method is quite as rapid and certainly as reliable. The general use of the polarizing saccharimeter, together with its advantages and disadvantages, and also the preparation of the urine for that purpose, have been so fully explained by Dr. Tyson that there is nothing further for me to add.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, February 2, 1888.

The President, A. Jacobi, M.D., in the chair.

Dr. Robert W. Taylor read a paper on

Xeroderma Pigmentosum, and its Relation to Malignant New Growths of the Skin.

The author continued the histories of seven cases of xeroderma pigmentosum which he had reported in two papers, the first published in 1877, the second in 1878, showing their further development and relation to malignant new growths of the skin, and also gave a synopsis of cases reported by other observers in different countries, the entire number being thirty-nine. One other was excluded as having an incomplete history. The first paper on the subject of xeroderma pigmentosum was published in a text-book by Hebra and Kaposi in 1870. A good proportion of the entire number of cases observed had been reported by American physicians. The name xeroderma pigmentosum was not altogether satisfactory, but it probably would remain because of its brevity. The parents of all of Dr. Taylor's cases were dark brunettes; those of six were Hebrews; they were healthy; all the children were dark complexioned and had dark hair, except one. Three were sisters, and their parents were cousins. Two others were cousins of these, and their parents were second cousins. One patient had died of drowning before the development of malignant disease. Three of the others had epithelioma on some part of the face. The clinical history in the seven

cases was very similar, and was clearly portrayed. The disease consisted in telangiectasis, pigmentous and atrophic changes, which had close anatomical relations. To these polymorphous lesions were superadded new growths, which at first were benign in character, but which might become malignant. In six of his cases, according to reliable testimony, the disease began about the fifth or sixth month of life, and in one at the fourteenth month. He was skeptical about three cases reported as xeroderma pigmentosum beginning at the sixteenth, ninth, and ninth years respectively. The development of epitheliomatous and other malignant growths on the face of persons subject to deep or light pigmentations did not necessarily constitute xeroderma pigmentosum. The weight of evidence, therefore, placed this disease as one of very early childhood.

The invasion of xeroderma pigmentosum was very constant, beginning about the face and under the eyes as a well-marked smooth superficial erythema, which was often regarded by parents as the result of sunburn. The patches gradually spread over the face and neck and stopped abruptly at about the third rib. Its duration varied from one to seven months, during which the erythema might become less red, while pigmentous patches developed, at first of light-brown, then becoming darker, perhaps black. They varied in size from that of a pinhead to that of a lentil. Scattered among them were telangiectasic spots. With the evolution of these lesions there were no marked local subjective symptoms. If the case were carefully studied and frequently observed in these irregular patches, it would be very often plain to the eye that the pigmentary spots followed exactly upon the pre-existing red spots, and the conclusion would be obvious that the red lesion was its forerunner and its pigmented fellow its sequel. These lesions had exacerbations and remissions. As the child grew older the disfigurement became worse. There was no record of a case in which anything like an amelioration in its course had been observed. In the milder cases there was liability later in life to severe lesions.

The telangiectasis and the pigmentation were lesions of what might be called the hypertrophic stage of xeroderma. In some cases there were soon superadded atrophic changes. In the majority of cases these began at about the end of the first year. Their course was subject to marked exacerbations and remissions. They were not symmetrical on the two sides. As they progressed, they produced hideous deformities by reason of the size and situation of the patches. The skin became reduced to the thinness of parchment; nearly all the follicles were destroyed; vessels could often be seen beneath. The hands and arms, feet and legs, showed the changes less well marked. Atrophic changes were especially liable to be marked upon the forehead, scalp, eyes, nose and mouth, and might create partial stenosis of the nose and mouth. It was an interesting fact that when the atrophic process was at an end, no further pigmentation took place. Excessive hypertrophic changes took place very often coincident with the atrophic changes. There were also found epithelial new growths in rudimentary form, which might go on to malignant new growths. These tumors were liable to fall off and leave a fungous, oozing surface, which might become malignant. Such tumors and oozing surfaces should be removed or scraped by the sharp spoon. Of the thirty-nine cases, malignant new growths were known to have developed in sixteen, and non-malignant growths in six. Of course, the latter might yet become malignant, and some not yet affected by malignant or non-malignant growths might become so. Most of the new growths developed before the tenth year; there was nearly equal tendency to them between the tenth and twentieth years. There had been no evidence of metastasis during life or at autopsy.

The author thought the facts in the cases bore out Kaposi's explanation of the occurrence of epithelioma at so early an age, viz.: that it was due to the rapid changes going on in the epithelial layers. No successful remedy had been found. Surgery should be resorted to for the removal of tumors and fungoid surfaces. The sooner they were destroyed, the less the likelihood of their change into malignant new growths.

THE PRESIDENT suggested the use of arsenic and phosphorus in treatment, for the purpose of causing nutritive irritation in the connective tissue, which seemed to be lacking, probably because of failure of embryonic cells to undergo their usual change after birth.

—The Otological Congress will be held at Brussels from the 10th to the 15th of September next, and it will be followed by the meeting of the German doctors and naturalists at Cologne. Dr. C. Goris, 143 Rue Royale, Brussels, will receive all announcements for the Otological Congress, which may be sent to him.

Reports of Clinics.

COLLEGE OF PHYSICIANS AND SURGEONS.

MEDICAL CLINIC—PROF. DELAFIELD.

Two Cases of Incipient Phthisis.

Case I.—At the Vanderbilt Clinic, January 12, 1888, the first patient introduced by Prof. Delafield was a young man who gave the history of a single hæmoptysis. After the physical examination, Dr. Delafield said: The patient is a very good example indeed of a class of cases we see more frequently in private practice than in dispensaries and hospitals. We find, often enough, patients coming to us with just the history which this man gives: a young man or a young woman who has been in ordinary health, with no cough, no running down, suddenly coughs up a little blood. The quantity of blood which such persons will cough up varies; it is, as a rule, not great; it may be only a few mouthfuls; it may be a cupful. In some, there may be a history of only a spitting up of blood; in others, it may have been repeated two or three times, but each time only a small quantity is raised. Between the attacks they may have a little cough, but not much. These will be all the rational symptoms the patients will give. This young man continued to have a good appetite; he slept well at night; he did not feel sick. But, on the other hand, if the patient is of a more excitable temperament, you may rely upon some constitutional disturbance. Many such patients will tell you they have no appetite; they feel very weak; they do not sleep at night; they feel very badly. Now, all this means the individual; it does not mean the disease. In most of them you will find no rise of temperature; in a few, there will be a little rise. The pulse is usually rapid, somewhere about 100°, as in this young man.

After getting the history of these patients, the next thing is to examine the chest. In some of them you will get absolutely no physical signs of disease; in most of them there will be no change in the breathing or percussion note over the entire chest. In other patients, there will be physical signs, but they will be very slight indeed. In these patients there is no consolidation of the lungs. When you listen to the breathing you will, in some patients, get a little information. The locality at which you will get this information varies in different cases. In some, it will be just at the apex on either side beneath the clavicle; in others, it is lower down in front, but not in the intermediate position. In other cases it may be over the upper part of the chest behind. What you first notice is change in the character of the breathing; this change is perhaps impossible to describe in words, but there is a difference in the breathing over the two lungs. There may be added to the change in the character of the breathing a few subcrepitant râles—not many, but a few. Now, with these very few physical signs, or no physical signs at all, you will be called upon to say whether the patient has or has not commencing phthisis, and you see how very difficult indeed the problem is to solve. It is easier to solve in men than in women, for men are less likely to bleed in this way than are women without showing changes in the lungs.

Suppose the case of a young man, like the one before us; it will make a difference, in the first place, as to what the patient tells you of the character of the bleeding. If he has had a single large hemorrhage, taking place within a short time, it will not be as much an indication of commencing phthisis as if he had had several smaller hemorrhages. The more frequently the hemorrhages have been repeated, so much the more likely are you to find disease of the lungs. Then you have to look at the throats of such patients, and see whether there is marked evidence of pharyngitis. This young man has none at all. Then you inquire particularly whether there has been any change in the general health. Sometimes on close questioning you will find that although the patient has considered himself well, yet he has not been in as good health as for sometime before; he has been running down, losing flesh and strength. Still further, you will inquire into the family history, to find out whether there is any hereditary predisposition to lung trouble. Thus you try to get all the collateral information you can about the health of these patients before you make up your mind as to what is the matter. Still further, in interpreting the physical signs, if there be any, you must have some definite idea of what they may mean. For example, in this young man the only physical signs are, that behind, over the upper part of the right lung, there is a little change in the breathing, and there are a few subcrepitant râles. Now, in interpreting those physical signs, there are two points to be borne in mind, namely, the mechanical conditions which produce

them, and the significance which they possess. In interpreting these physical signs we must take into consideration the patient's history. If this patient had come here without any history of spitting up of blood, but simply complaining of a little pain over the right shoulder, I would suppose that the subcrepitant râle present here was due to fibrine on the pleura, and that very probably the man had only a localized pleurisy. But when I get the history of a young man spitting up blood for several days in this way, and in his usual health, I think those subcrepitant circumscribed râles mean something else; I think they mean either a little mucus or a little blood in some of the small bronchi of that part of the lung. The sound is just the same, but the way in which it is produced is different. But with the history given, I do not draw the inference from these physical signs that the patient has simply a localized bronchitis. The inference which I draw therefrom is that there are a few scattering miliary tubercles in the upper part of the right lung; these miliary tubercles, as such, not taking any part at all in the production of the physical signs.

It is hard to realize in these cases of early phthisis that what is really of consequence is not the part which at first gives the patient either the symptoms or the physical signs. It is not the fact that there are tubercles in the upper part of this man's lungs that is occasioning the hemorrhage. It is not their presence which is occasioning the subcrepitant râles; yet we know by putting such cases together over and over again that with such a history and such physical signs we may be reasonably sure that there are miliary tubercles in the patient's lungs. Still more than this, we may be pretty sure that if he had not miliary tubercles he would not have had the bleeding, and he would not have the physical signs.

I think, then, in this patient's case there is no question about the diagnosis. He has phthisis in its very earliest stages, consisting of a very few miliary tubercles in the upper part of the right lung. As a symptom of this change in the lungs he has had spitting of blood, which, by the by, comes from the bronchi of that lung, and from the larger bronchi, not from the lung tissue. With this bleeding from the bronchi there has been a very small degree of bronchitis, or perhaps no bronchitis at all. Perhaps the subcrepitant râles are due simply to a little blood which has been expelled from the larger bronchi into the smaller ones.

As to the treatment, I think one has to admit that such patients as these really can get well without doing anything at all. I think it is possible for a young man like this to stay in the same place, go on with his work, and have no further symptoms at all, and if he should die years afterward from some other cause, you would find in the upper part of his lung the miliary tubercles which are there at the present time, the disease not having progressed. This is, I think, possible for these patients; the probability, however, of their getting entirely well is very much decreased if the patient cannot take proper precautions in preserving his health. The best precaution of all is probably one which this young man cannot take, and that is getting the beneficial effect of change of climate. If you could do just what you think is the very best thing to do for a young man coming to you with such a history, and with such physical signs as these, you would tell him to go away for one or for two years, and during that time to travel about from place to place, not staying in any one locality, not looking out particularly for climates which are considered good for patients with phthisis, but simply getting the beneficial effect on his whole body of traveling and moving about from place to place. If he cannot do this, the best thing he can do is to try to remedy any defect which there may be in his general health. Take the case of this young man. He is sufficiently well nourished; that is, he has fair weight; there is no object in giving him cod-liver oil; there is no object that I know of in giving him stimulants. There are only two points about his case which suggest themselves to me as giving indications for treatment. One of these is his occupation. He is a cigar-maker. That unquestionably is an unhealthy occupation for a young person with lung trouble of this kind, as the dust from the tobacco is constantly being inhaled. He is still young, and if it is possible for him to take up some other business it would be very much to his advantage.

Then in color he is slightly anæmic; and this indicates the administration of iron. In this case, then, all that is necessary is to advise him to learn some other way of earning his living than working in tobacco, and have him for a time take iron in moderate doses.

Case II.—This case makes a sort of continuation of the one which we have just been considering. The man is 30 years old, and instead of raising blood only six days before coming under observation, he has been having hemorrhages during the last eighteen

months, but much in the same way as the other patient. Although the duration in this second case has been longer, yet you will observe there is the same paucity of symptoms as in the other. He has no cough except at the times he raises blood. He is not short of breath; he has no great amount of pain about the chest; his appetite is fairly good, but latterly he has lost flesh to some extent; that is all. Now in his case we ought to find more physical signs, and rather different physical signs from those we found in the previous case. There is a little depression under the clavicles, but it is about the same on both sides. You will notice the difference in the percussion note on the two sides. On the right, beneath the clavicle, the resonance is fair enough; but on the left the pitch is higher, and the sound is a little shorter. The breathing is not quite as loud on the left side of the chest beneath the clavicle as it is on the right, and the voice is decidedly more feeble.

This man began eighteen months ago, just as the preceding patient has begun recently, with a few miliary tubercles in the lung; but, instead of having them in the upper part of the right lung, he has had them in the upper part of the left lung. Whether he had any physical signs eighteen months ago or not, of course we do not know; but he had the same spitting of blood. He has gone on from that time to the present, spitting blood occasionally; yet, for the most part, not feeling sick; able to work; but latterly he has lost flesh. He says he could work, but he has nothing to do. When we come to examine his chest, we get the physical signs which we would expect to find with his clinical history. We no longer get any râles, although in other patients of this kind we might very well get some subcrepitant râles. All we get is dullness on percussion, not very marked, the breathing not as loud, and the voice not as loud under the left clavicle as under the right. These are the physical signs.

Now, what is the change which has taken place in his lung? It is a very limited one, indeed. It involves only the apex of the left lung. Here at the apex is the same moderate number of miliary tubercles as in the previous case. But, as this man's trouble dates back eighteen months, there has been time for changes to be added to those of miliary tubercles, and it is these other changes which give rise to the physical signs. In the first place, the pulmonary pleura is thickened over or just below the apex of the lung. In all probability, there are some adhesions between the pulmonary and costal pleura at this point. Then in the lung itself, besides the miliary tubercles, which still are few in number, there is a little diffuse fibrous tissue. It is not the tubercles which give us the dulness; it is the thickening of the pleura; it is the pleuritic adhesions and the fibrous tissue in the upper part of the chest which give us the difference in the percussion note, voice and breathing. It is easy enough to say why these changes produce the difference in the percussion note, but it is not by any means easy to say why they give the difference in voice and breathing. We know by experience that they do so; we see it, over and over again, that those are all the changes in the lungs to account for the voice and breathing being diminished.

In this man, then, we have chronic phthisis lasting eighteen months, yet at the end of that time he has but very slight pathological changes in the lung. In such a case as this the prognosis is comparatively good. It is perfectly possible for such a patient to get well. As to what we can do for him, the rule is just the same as in the preceding case. If it were possible for him to go away and stay away, it would be the best thing he could do. His occupation, when he has it, is that of a salesman, which is a good enough business for a man suffering from his trouble. Just now, unfortunately, he is out of work, and leading the very demoralizing life which belongs to a man without work. He has nothing to do all day, and he loafs about the house, and has not sufficient exercise either of body or of mind. He unquestionably would be better off if he had something to do. In the next place, in this man there is an indication for fattening food. He has lost flesh. He is somewhat emaciated. His lips are not particularly anæmic. I do not know that there would be any particular object in giving him iron. I would rather give him cod-liver oil.

—Dr. George S. Meigs, a dentist living in New York, killed himself Jan. 23, 1888, in his operating-room. He had become subject to extreme nervousness, which interfered with his work and kept patients from him. When utterly prostrated, he consented to try the so-called "Christian Science," in the hope that it might restore him to health. It failed, and in despair the wretched man put an end to his life. He made death sure by drinking enough prussic acid to kill twelve men. He stated, in a letter to his wife, that he wished to be cremated.

PERISCOPE.

Contributon to the Etiology of Neuralgia.

In the *Edinburgh Med. Journal*, December, 1887, Mr. James R. Whitehall says there are many conditions classed under the heading neuralgia. There is the pure form, with no apparent and definite cause during life, and leaving no discoverable lesion after death; the reflex form, which may be, and frequently is, due to dental caries and other remote causes, the removal of which gives speedy relief to the symptoms. Then, again, there are other forms due to an actual inflammation of the nerve—a true neuritis and not a neuralgia at all; others due to poisons circulating in the blood, such as lead, the poison of syphilis, gout and malaria; and some to pressure upon the trunk of the affected nerve, or to an irritation still higher in the course of the nerve. In the pure form of neuralgia, where there is no apparent cause except the debility so frequently associated with it, the author thinks it is impossible to distinguish during the attack these three different kinds of pain: First, a more or less continuous throbbing pain; second, a sharp, lightning-like pain, succeeded frequently by a burning or tingling sensation; third, a superficial cutaneous hyperæsthesia, the "points douloureux" of Valleix. The throbbing pain he attributes to a dilatation of the vessels of the nerves themselves; the sharp, lightning-like pain to a more acute compression of the nerve, brought about by a sudden alteration in the blood pressure, or an increased dilatation of the already dilated blood-vessels, perhaps from such slight causes that they usually escape notice. With regard to the production of the tender spots of Valleix, the explanation is ingenious. As the nerve, he says, passes on its course, it gives off filaments to the surrounding parts, and these filaments come off from the main trunk in a definite order from without inwards; therefore the most superficial filaments of a nerve-trunk are those which supply the tissues in the immediate vicinity. But it is these very filaments which suffer most when a nerve is compressed in the osseous or other canal; and therefore, by the law of eccentric projection, there is a hyperæsthesia in the part supplied by those filaments—in fact, a tender spot. And since these filaments suffer most, it is not at all unlikely that, as the attack progresses, the prolonged pressure would temporarily destroy their function and cause local anæsthesia; and this is exactly what occurs—hyperæsthesia being more likely to occur at the earlier part of an attack, and anæsthesia later.

He considers the treatment of neuralgia under three headings, namely: 1, external local; 2, external remote; 3, internal.

1. Of the local methods of treatment, such operative methods as incision and division of the nerve sufficiently explain themselves. Stretching the nerve and acupuncture seem to act in the same way, probably by causing a solution of continuity in the sheath, and thus relieving tension, and diminishing the swelling of the nerve. As regards stretching, however, Callender considers that "it is probable that the stretching is of use by numbing the nerve for a short time." If this be really true, the natural explanation would be that the sensory irritation resulting from the hyperæmia would for a time cease, and on its cessation the reflex dilatation of the blood-vessels would also be brought to an end. Electricity, again, in common with belladonna and heat or cold locally applied would contract blood-vessels. Belladonna, volatile oils and their stearoptenes,[1] such as thymol and menthol, also chloroform, not only contract the blood-vessels, but also diminish the sensibility of the part, while aconite locally applied acts purely as an anodyne.

2. Of the external and remote methods of treatment, counter-irritation over the upper part of the dorsal spine, which apparently does good in some cases, must be mentioned, though perhaps somewhat difficult to explain, unless possibly it has some action on the sympathetic vaso-motor fibres which emerge from the cord about this level in the anterior roots of the lower cervical and upper dorsal nerves (Foster). Ligature of the carotid is an eminently successful, though somewhat heroic treatment, and has been very successfully employed by Dr. Patruban in many cases of severe neuralgia—this, of course, acting directly on the blood-vessels, the idea of the operation having originated from the relief obtained in some cases by simple pressure on the carotid.

3. Of the internal treatment of neuralgia the substances used fall naturally into four groups:

(1.) Those which contract blood-vessels, such as strychnia, atropia, and its allies, bromide of camphor, digitalis, ergot, volatile oils, such as turpentine, chloride of ammonium and quinine, though certain of these also have a specific action on sensory nerves in addition.

[1] Solid crystalline compounds separable from volatile oils by cold.

(2.) A second group consists of bodies which act as general tonics, such as quinine, iron, strychnia, phosphorus and arsenic. The experience, however, of arsenic and phosphorus seems to indicate that they have some more direct action than simple tonics.

(3.) A third group consists of simple anodynes or sedatives, such as bromide of potassium. This, however, like chloral, diminishes the pulse tension, and in addition diminishes reflex excitability by depression of the peripheral sensory filaments. Other drugs, such as cannabis indica and morphia, seem to act as simple anodynes.

(4.) The fourth group consists of the usual tell-tale drugs, which are always appearing, and of the action of which no very apparent explanation can be given. Amongst these gelsemium sempervirens is a prominent member, and probably also arsenic and phosphorus.

He concludes by saying that there are, then, symptomatic, pathological, etiological, and therapeutic reasons for believing that the blood-vessels are at fault in cases of neuralgia, and therefore, on this view, it seems necessary to consider true neuralgia as a sympathetic neurosis, affecting certain tracts of cerebro-spinal nerves, resulting in simple dilatation of the vessels of these nerves, brought about by unknown causes, or by reflex irritation, or possibly by the specific action of certain poisons in the blood.

Sulphate of Sparteine.

The *Deutsche med. Wochenschrift*, in a review of sparteine, remarks that it is the alkaloid of broom, and belongs to the alkaloids which have no oxygen in their composition. The sulphate is employed for medical purposes, because it is more easily soluble and less easily decomposed than the other salts. It forms large, translucent, colorless rhomboid crystals, readily soluble in water, and of a bitter taste. Germain Sée found that it possessed a stimulating action upon the contractions of the heart, slowing its action; and that it increased the arterial tension, and also increased the flow of urine. The rhythm of the heart's contractions was restored in only a few cases. The action of sparteine was rapid, but was not maintained sufficiently long at its height to remove the disturbances in compensation; and even when given in repeated doses does not achieve any such persistent action as is obtained through the use of digitalis. Voight, however, recommends it in valvular disease, with and without the disturbances in compensation which are proper to it. He also recommends it as a regulating and calmative agent, in insufficiency of the heart muscle without disease of the valves, in pericarditis, and finally as an adjuvant in combination with digitalis. The dose is about one-third of a grain, three times a day. The following formulæ are given:

℞ Sparteini sulph.....gr. iij
Aquæ destillat.....f℥ij¼
M. Sig.—20 drops in sweetened water or wine, two to four times daily.

℞ Sparteini sulph.....gr. iij
Syr. aurantii cort.....f℥iij
M. Sig.—Dose, a small spoonful in water, four times a day.

Saccharin in Diabetes Mellitus.

Kohlschütter and Elsasser report to the *Deutsches Arch. f. klin. Med.*, xli, S. 178, that in a case of severe diabetes affecting a man 30 years of old, which was treated with saccharin in daily doses of 15 to 30 grains, a considerable though transient diminution in the quantity of urine and sugar was brought about. During the employment of these large doses, anorexia persisted. The patient complained of a persistent disagreeable sweet taste, even when the saccharin was given in pill form, which taste hindered the taking of nourishment through the disgust it produced. The authors refer the diminution in the quantity urine and sugar excreted to the smaller quantity of food taken. But inasmuch as the saccharin effected no increase in the production of sugar, it may be used without injurious results to sweeten food and drink in diabetic patients. In one case in which the drug was given in this way the sweet taste of the saccharin was noticeable throughout in a disagreeable way.—*Centralblatt f.d. med. Wissensch.*, Jan. 7, 1888.

Case of Carcinoma of the Cervix in a Virgin.

Eckhardt reports this case to the *Arch. f. Gynecologie*, xxx, S. 471. It is interesting from the fact that a cancerous tumor, the size of a child's head, which arose from the hypertrophied posterior lip of the uterus, was found in a girl who was unquestionably a virgin. This tumor was removed by means of the galvano-cautery écraseur. The cause of the snout-shaped hypertrophy, as well as of the carcinoma, is stated to be chronic irritation from masturbation. At first the tumor was thought to be a carcino-sarcoma; but on microscopic examination epithelioid cells with large nuclei were found, not spindle cells.

Foreign Body in Wharton's Duct.

At the meeting of the Boston Society for Medical Improvement, November 28, 1887, Dr. A. T. Cabot showed a piece of brown straw, one inch and one line in length, and as large as a No. 5 needle, which had lodged for six months in Wharton's duct. The patient, a young man, lost a piece of straw under his tongue on the 14th of May, 1887. For three or four weeks he experienced no trouble from it. Then a somewhat painful swelling of the submaxillary gland upon that side occurred. When seen in August, the submaxillary gland contained a hard swelling about the size of a robin's egg, and in the line of the duct, about one inch from its orifice, was a little hard swelling as large as an apple seed. Pressure along the duct caused the issue of a drop or two of pus. The bit of straw being supposed to be very small and evidently lodged far back towards the gland, a cutting operation in search of it seemed unadvisable, and the patient was advised to press occasionally over the gland, and then along the duct, so as to force the pus and secretion out, in the hope of working the straw out along with it. This milking the gland and duct was followed by a decided increase of pain and swelling, but it was continued at intervals until October 1. At this time a little abscess formed over the duct, and was punctured by the patient. A few drops of pus appeared. On November 15, the patient found that when he gaped and raised his tongue, the duct was so shortened that the tip of the straw appeared at the orifice. After some trouble he succeeded in seizing the end with a fine pair of scissors and withdrew the straw.

Poulet, in his exhaustive work on "Foreign Bodies in Surgery," has succeeded in finding but six authenticated cases of foreign bodies in Wharton's duct. In one of these the foreign body was, as in this case, a bit of straw introduced while picking the teeth. A very severe inflammation followed in the case reported by Poulet, and, abscesses forming, the straw, which was two-thirds of an inch in length, was finally discharged spontaneously in two pieces. A careful search in this case at the time of opening the abscesses failed to find the straw. In answer to a question by Dr. Hooper, Dr. Cabot said that if he had suspected the size of the straw, he would have made an incision of the duct, and would have hoped to find it. The evidence at the time he saw the patient, however, was that the bit of straw was extremely small, and far back towards the gland, where the chances of finding it were but slight. As the patient was suffering no pain, it seemed better, therefore, to wait and try to work the straw forward to where it could be easily reached. That it was worked forward by the manipulation practiced seemed probable by the result.—*Boston Medical and Surg. Journal*, Dec. 22, 1887.

Chloroform and the Constant Current in Neuralgia.

Prof. Adamkiewicz says he has obtained marvellous results from the combined action of chloroform and the constant current in facial and other forms of neuralgia. The electrode is made of hollow charcoal into which the chloroform is introduced, and from which the current sends it into the tissues. That this power of penetration may be thus obtained is thought to be shown in the fact that when chloroform is colored with gentian violet and applied in the manner described to the ear of a rabbit, the tissue becomes dyed. In the experiments with the human subject, the writer notes, at the commencement, the triple action of the constant current, the chloroform and a condition of cataphoresis followed by a burning sensation and, finally, anæsthesia. Several remarkable cases of cure are cited. Anæsthesia was not obtained when the nerves were deep-seated, nor in sciatica.—*Progrès Médical.*

Tinea Decalvans.

At a recent meeting of the Academy of Medicine of Paris, a discussion took place on the contagiousness or non-contagiousness of tinea decalvans, but without much satisfactory result on either side. Dr. Ollivier has for the third time brought the subject to the notice of the Academy. The author protested vehemently against the exclusion in schools of the pupils who are affected by it, on the ground that it was not a contagious disease. Dr. Ollivier believes that tinea decalvans is caused by a sudden nervous perturbation, an unexpected emotion, or by very great sorrow. He would therefore recommend that the quarantine to which such pupils are subject should be removed, and that they should be allowed to prosecute their studies in common with the others. Dr. Hardy, the well-known dermatologist, declared that he entertained an opinion diametrically opposed to that of Dr. Ollivier. Prof. Cornil shares Dr. Ollivier's opinion, and stated that what tends to prove the non-transmissibility of tinea decalvans is that one does not find in this affection either cryptogams or micro-organisms, which could produce it.—*Lancet*, December 17, 1887.

Impaction of a Foreign Body in the Pelvis.

Upendra Nath Sen relates, in the *Indian Medical Gazette*, September, 1887, a remarkable case of impaction of a foreign body near the rectum. A washerwoman, aged 25 years, subject to epileptic fits, had an attack whilst in a standing position and fell over a bamboo. By the force of the fall a piece of a bamboo branch broke, and penetrated very deeply half an inch to the right of the anus. The wound proved to be very small, only admitting a probe, which entered to the depth of five inches; the presence of a foreign body could not be detected in it. As this, however, might have found its way into the rectum by the force of the fall, an exploration was made with the finger, whereupon a hard substance was felt in a vertical position by the side of the rectum, about two inches beneath the surface of the skin. The writer cut freely to the depth of two inches over the suspected part, and succeeded in feeling the end of the foreign body with a probe. He then enlarged the wound to the required extent, to facilitate the extraction of it, and with a strong forceps removed an entire piece of a bamboo branch four inches long and as thick as a full-grown finger. It is worthy of notice that the patient walked from her home, a distance of two miles, a fortnight after the accident. The woman is now doing well.—*Practitioner*, Dec., 1887.

Venesection.

At the meeting of the Clinical Society of Manchester, November 15, 1887, Dr. Addy (*Brit. Med. Journal*, Dec. 17, 1887) related three cases in which bleeding was performed, in two of which it rescued the patients from imminent death. The first case was that of a man, about 50 years old, who had suffered from hematemesis, cirrhosis, ascites and albuminuria. After recovery from these ailments, the patient, who had also aortic disease and high tension pulse, was seized with convulsions, lasting more than an hour; he became unconscious, cyanotic and breathed with great difficulty. About twenty ounces of blood were removed from the arm; the convulsions ceased, consciousness returned in twenty-four hours, and the patient had continued in good health for twelve months. The second case was that of an elderly woman, who was suddenly seized with violent coughing and dyspnœa, the lungs becoming rapidly engorged. On admission, the patient was almost pulseless, and apparently moribund. Venesection was performed, with almost immediate relief to the breathing, and the patient rapidly recovered. This patient suffered also from chronic Bright's disease. The third case was that of a young man, suffering from acute pneumonia; congestion of lungs rapidly supervened, and the patient seemed fast sinking. Bloodletting was tried, and relieved the embarrassed lungs and heart; but the improvement was only temporary.

Treatment of Rheumatism and Rheumatoid Arthritis.

At a meeting of the West London Medico-Chirurgical Society, held Dec. 3, 1887, Dr. Saville read a paper on the treatment of rheumatism and rheumatoid arthritis. The author took a peculiar interest in the disease, for he himself had been a martyr to it in its subacute form. He classified rheumatism into (1) acute, in which the temperature exceeded 102°; (2) the subacute, in which the temperature never reached 102°; and (3) the chronic form. He considered that the amount of fever and constitutional disturbance usually varied inversely as the age of the patient. He thought that the treatment of acute rheumatism by the salicylates of soda and potash, the best yet devised; and contrasted the old cases as described by Dr. Fuller twenty-five years ago—the majority of which lasted four or five weeks and upwards—with the experiences of the present day. The salicylate, properly used, now made the temperature go down in a few days, and in nearly every case the patient was quite cured within the month. He had seen no evidence that visceral complications were more frequent under the treatment. The failure of the drug may be due to three things: (1) Unsuitability of the cases, *e.g.*, where renal disease is present; (2) the mode of administration—large doses being requisite; and (3) errors of diagnosis—gout and septicæmia having been mistaken for rheumatism. He recommended graduated baths. In one case everything failed to relieve the pains but hypodermic injections of morphia. Dry and hot cotton-wool often gives relief. In the subacute and chronic forms he has tried many remedies, but cannot believe much in any of them. Saline purgatives and diuretics may be useful. Sometimes Scott's dressing and other applications, care in diet, avoidance of alcohol and sugar, warm clothing, a course of Turkish baths and massage—especially for muscular rheumatism, will be beneficial. Change of climate, mineral baths, and particularly pure sea air, as on a voyage, are useful by inducing metabolic change.—*Medical Press and Circular*, Dec. 14, 1887.

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EXCISION OF THE RECTUM—KRASKE'S METHOD.

At the Fourteenth Congress of the German Society of Surgeons, in 1885, Prof. Kraske, of Freiburg, proposed an ingenious method of operating for cancer of the rectum, which consists in approaching the diseased tissue, not from below but from behind, after removal of the coccyx, division of the left sacro-sciatic ligament and, if necessary, removal of part of the sacrum. Since this time, other surgeons have tested Kraske's method, and have found that it not only makes the removal of a portion of the rectum a more exact, and, in some respects, an easier operation; but also makes it possible to remove a portion much higher up than could be reached by any operation according to the older methods.

In his first description of his method, Kraske recommended, in cases in which removal of the coccyx and division of the sacro-sciatic ligament did not furnish room enough for access to a morbid growth situated high up in the rectum, that the sacrum should be chiselled away below a curved line passing from its border, at a point on a level with the third sacral foramen, to the border of the lower horn of the sacrum. Bardenheuer has proposed, as a better plan, a transverse exsection of all of the lower part of the sacrum. This plan is not only approved by Kraske, when it is absolutely necessary, but it was actually suggested by him in his first publication on this subject and has been done by him in one case. The consequences were not unfavorable in this case; but Kraske naturally and sensibly contends that such an exsection should not be regarded as preferable to removal of part of one side of the sacrum, except when the latter is insufficient for gaining access to the portion of the bowel to be removed.

In a paper in the *Berliner Klinische Wochenschrift*, Nov. 28, 1887, Kraske describes the method which, after considering the various proposals which have followed the first description of his method, he believes to be the best. This consists in placing the patient on his right side; making an incision from the middle of the sacrum to the tip of the coccyx, going down to the bone; detaching the soft parts on the left to the border of the sacrum and coccyx; division of the left sacral and coccygeal ligaments up to the level of the third sacral foramen; division of the soft parts over the coccyx to the right, and exsection of the coccyx with bone forceps. If now, when the soft parts are held apart with retractors, the portion of the rectum to be removed is accessible, its removal can be proceeded with. If it is not accessible, then the part of the sacrum indicated above may be chiselled away. If this does not furnish room enough, the sacrum may be reached at the level of the third foramen.

In regard to the actual removal of the diseased portion of the rectum, Kraske describes two methods: one proceeding from the anus, when the disease extends so low down that the lowest portion of the bowel cannot be saved; and the other following the general line of the preliminary removal of the bone, when the lowest portion of the rectum is not implicated. The limits of our space compel us to refer our readers to Kraske's

paper for the details of this part of the operation, which involve considerations which cannot be stated briefly.

Kraske urgently recommends saving the anus, with its sphincter, whenever it is possible, and suturing the upper portion of the bowel, after its resection, to the lower portion; and he has found it possible in his practice to do this successfully. In the paper to which we have referred Kraske gives an account of eight cases in which he has practiced his method, four of the patients dying soon after the operation, and four making a good recovery. In two of the latter cases the function of the anus was so good, after the wound healed, that the stools were passed in the normal way.

The opinions of Kraske appear so sound in theory, and they are so well supported by the results which he has secured, that they deserve the most careful consideration of surgeons, and we hope that they may receive such consideration, and a fair test in practice, not only in his own country, but also in ours.

OPERATION FOR ABSCESS OF THE SPLEEN.

In the *Deutsche Med. Wochenschrift*, December 22, 1887, Dr. Carl Lauenstein, of Hamburg, describes a case in which there was enlargement of the spleen, chills and fever, with pain in the region of the spleen, following an illness which had been diagnosticated as typhoid fever. After studying the symptoms carefully he came to the conclusion that there was an abscess in the spleen, and decided to operate for it. In carrying his decision into effect he first plunged an aspirator needle through the chest wall in the line of the axilla, passing through the eighth intercostal space, the pleura and the diaphragm, and into the spleen. Upon finding pus, he then—leaving the needle in place—resected a portion of the ninth rib as long as a finger. After this he proceeded to cut down upon the spleen with the thermocautery, and opened a pus cavity as large as a goose-egg. After fixing the spleen to the edges of the incision with tenacula, he washed the cavity out with a cold solution of salicylic acid, and tamponed it with iodoform gauze, and surrounded the chest with an antiseptic dressing. The subsequent history of the case was very satisfactory, the patient making a good recovery in about six weeks.

With this experience to guide him, Lauenstein has studied the literature of operations for abscess of the spleen, and has found none which is exactly like his own. Reflecting upon his operation and its results, he is disposed to attribute his success, in a large measure, to the preliminary partial emptying of the pus-cavity with the aspirator and the consequent diminution of tension in it, and to his leaving the needle in place while he completed the subsequent part of the operation. Another thing which contributed to the fortunate result in this case was the fact that the diaphragm was adherent to the wall of the chest, and was incapable of movements which might have contributed to infection of the peritoneal cavity. A practical conclusion from the features of this case is the opinion of Lauenstein that fixation of the diaphragm and basal pleuritis are not only important diagnostic signs in abscess of the spleen, but that they contribute materially to success in any operation for its relief.

This experience of Lauenstein, and the conclusions to which he has come in analyzing its details, are of more than ordinary interest for surgeons, and for physicians as well, to whom, in the first place, patients with diseases of the spleen present themselves. The operation which proved so successful in this case is not likely to be soon repeated; for such cases are fortunately very rare. But it is good to know what has been accomplished in one of them, in order that no patient may be permitted to succumb to an abscess of the spleen without duly weighing the possibilities of an operation for its relief.

LEGAL REGULATION OF THE PRACTICE OF PHARMACY.

There is, according to the *Concours Médical*, December 10, 1886, a proposed law before the Chamber of Deputies, of France, in regard to the practice of pharmacy, which has

some points of interest for physicians and pharmacists everywhere. The law makes a proper restriction of the exercise of pharmacy to those who have received a diploma of fitness. It also forbids any association between a druggist and a physician for their special profit, or for the pushing of a special preparation. It also forbids the practice of medicine and of pharmacy by the same individual, even if he has taken a diploma in both sciences. Physicians may furnish medicine in cases of emergency and urgency when the distance to the nearest pharmacy is not less than five kilometers (about three miles). A pharmacist may sell any simple or compound remedy upon demand; but he may not sell a remedy composed according to a physician's prescription, provided the prescription is so formulated that it may be understood by any pharmacist. Hospitals, and various societies and associations indicated, may have pharmacies of their own, provided they are in charge of qualified pharmacists.

Some of these provisions for the legitimate exercise of the functions of pharmacy are excellent; but we cannot see why a man who has the legal qualifications for the work of a physician and for that of a pharmacist should be forbidden to prescribe and dispense medicines. There are reasons why it is not generally advisable for a man to undertake to perform the labors of two callings, each one of which may demand so much time and skill as to preclude the possibility of attending properly to the other; but, in this country, a restriction of this sort would work hardship in many places in which the population is not large enough to support a druggist in addition to a physician.

As to the provision that a physician may dispense his medicines only in emengencies, and when the distance to the nearest pharmacy is not less than three miles, it may be said that such a proposition would not be listened to in the United States, and it is not likely to be adopted in France.

With these exceptions, we believe the provisions of the proposed French law to be wise, and worthy of imitation here. Druggists as well as doctors would, we think, be glad to have laws adopted in every State which would protect honest and competent pharmacists in the exercise of their calling, and define clearly their relations to physicians and to the community, while restraining the incompetent or unworthy from disturbing the harmonious and reciprocal working of physicians and pharmacists in their labors for the health of their fellow-men.

CIGAR-MAKING AND INSANITY.

The New York *Tribune*, January 20, 1888, states that, when Mayor Hewitt recently visited the insane asylum on Ward's Island, he was struck with the remark of Dr. Macdonald, Medical Superintendent, that cigarmakers were more largely represented among the patients than members of any other trade. On asking for the statistics of this institution, Dr. Macdonald informed him that, in the fourteen years during which he has been medical superintendent, 5733 patients have passed through the asylum. Of these there were: bakers, 79; barbers, 56; bricklayers, 31; butchers, 74; carpenters, 141; cigarmakers, 163; cooks, 52; masons, 66; painters, 126; plasterers, 17; plumbers, 37; printers, 94; shoemakers, 143; tailors, 178. Dr. Macdonald ascribes the large number of insane cigarmakers to the unhealthfulness of the surroundings under which the trade is carried on in this city, a large proportion of the cigarmakers working, cooking and sleeping in the same atmosphere in their tenement-house rooms.

On the other hand, President Bayles, of the Board of Health, finds that from 1874 to and including 1883, when the law was passed forbidding cigarmaking in tenements, the number of cases of insanity was 112, a yearly average of 11.2; and from 1884 to 1887, 51, a yearly average of 12.75. The number of insane tailors from 1874 to 1883 was 122, a yearly average of 12.2; and from 1884 to 1887, 56, a yearly average of 14. Mr. Bayles points out that the average number of cases yearly among the cigarmakers increased after tenement work was abandoned. He, therefore, does not attach much

significance to Dr. Macdonald's table. From all the information he can obtain, he sees nothing objectionable in the business of cigar-making in the tenements. He thinks tailoring in tenements much more objectionable.

In this Mr. Bayles appears to be in the right, and the statement of Dr. Macdonald seems to be an illustration of hasty generalizing from too scanty premises. When the figures for cigar-makers (163) are compared with those for tailors (178), it would appear that working on tobacco is not so dangerous as working on dry goods; and when both are compared with those for carpenters (141) and painters (126), it would appear that working in tenements is not materially more dangerous than working in the open air or where the air is as pure as falls to the lot of any mechanics.

As a matter of fact, any assumption founded upon these statistics, in regard to foul air or tobacco as influencing insanity, would not be unfavorable to either of them; and the statistics cited by the *Tribune* illustrate the trap into which one may fall who strains an argument in what may be a very good cause. Working on tobacco may be dangerous to the health; but the attempt to show that insanity can be attributed to it becomes ridiculous in the light of the statistics of the asylum at Ward's Island, if they are correctly reported by the *Tribune*.

In Austria the method of executing criminals differs from that in vogue in America; and, though apparently more horrible in its details, is more speedily effective. The condemned man is placed against a post, at the top of which is a hook and at the bottom a pulley. A rope having a loop at each end is passed around the neck of the victim; another is tied about his feet, the end being passed through the pulley. Two assistants then lift the man, by means of the rope around his neck, about six inches, and suspend him from the hook at the top of the post. At the same time the other assistants pull with great force at the rope attached to the feet. Death ensues usually instantaneously, though there is a range from one-half to two minutes in many cases.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

CHEMICAL ANALYSIS OF HEALTHY AND DISEASED URINE, QUALITATIVE AND QUANTITATIVE. By T. C. Van Nüys, Professor of Chemistry, Indiana University. With 39 wood engravings. Large 8vo, pp. 187. Philadelphia: P. Blakiston, Son & Co., 1888. Price, $2.00.

In this manual, simple qualitative tests for analysis of the urine are given in full, and the rationale of chemical processes is fully explained, while to meet the requirements of students somewhat familiar with laboratory work, nearly all the methods employed in quantitative estimations are given in full; especially is this true in regard to processes peculiar to work in physiological chemistry. Five chapters are devoted to the Physical and Chemical Properties of Constituents of the Urine; one to the Examination of the Urine and Sediments; and one to the consideration of Concretions and Stones. The rest of the book is devoted to quantitative analysis.

The whole presents an admirable treatise on the subject of the examination of the urine, especially adapted to use in chemical laboratories, and suitable for men who wish to conduct such examinations in a strictly scientific way. It treats the subject in an exhaustive manner, and leaves nothing to be desired in the way of completeness.

If we were to criticise this work, it would be only from the standpoint of the average medical man, who would miss in it those practical applications of the information acquired in the laboratory, which are so great a help to the practitioner, as compared with the laboratory student. Most of the readers of the Reporter, we feel sure, would like to have the weights and measures which are given in the figures of the metric system, given also in English equivalents, or at least to have a comparative table of these measures embodied in the book. Such details are not needed by those who are daily engaged in the study of chemical problems; but most medical men cannot well get along without them.

With this exception, we find nothing to complain of in this book, which is clearly written, handsomely printed, and admirably illustrated.

SIMILIA SIMILIBUS CURANTUR? By Charles S. Mack, M.D. 8vo, pp. 31. Boston and Providence: Otis Clapp & Son, 1888. Price, 40 cents.

This little book is written by one who throughout it manifests a spirit so temperate and fair, that what he says merits very careful consideration. He is not a headstrong advocate of homœopathy; but he inclines to the belief that the application of medicines to the cure of disease may be guided by what is known as the law of similars. It is with some regret that we observe—after an admirable exordium—that the argument of this book is made in a vicious circle, and that its conclusion—moderate as this is—is not warranted by what precedes it. We have not space in which to expose what appears to us to be the fallacies of Dr. Mack's reasoning; but we must confess some disappointment that one who seems in many respects so well qualified to defend what he believes should not make out a better case for a belief which has always appeared to us to be illogical, but which we have no disposition to dismiss with a sneer.

After all has been said, we think no "law" of therapeutics can be stated which will bear close scrutiny; and that nothing better has ever been proposed for our guidance in the choice of remedies than the good old rule of experience—empiricism, in fact. So far, the pursuit of a "law" of therapeutics has been but a groping in the dark for most seekers after such a light, and a persistent following of an *ignis fatuus* for those who think they have found it.

Pamphlet Notices.

Foot and Mouth Disease as it Affects Man and Animals, and its Relation to Human Scarlatina as a Prophylactic, etc. By J. W. Stickler, M.S., M.D., Orange, N. J. From the *Medical Record*, Dec. 10, 1887. 31 pp.

Syphilis of the Endometrium. By T. A. Ashby, M.D., Baltimore, Md. From the *Maryland Medical Journal*. 16 pp.

Footprints of a Profession. By Horatio C. Meriam, D.M.D., Salem, Mass From the *Archives of Dentistry*, Nov. and Dec., 1887. 21 pp.

Miscellaneous Reprints. By James Craig, M.D., Jersey City, N. J. 31 pp.

The Eye of the Adult Imbecile. By Charles A. Oliver, M.D., Philadelphia. From the *Medical and Surgical Reporter*, Sept. 17, 1887. 4 pp.

Traumatic Hæmatoma of the Larynx. By J. W. Gleitsmann, M.D., New York. From the *Medical Record*, Oct. 29, 1887.

Hypertrophy of the Tonsil of the Tongue. By J. W. Gleitsmann, M.D., New York. From the *Medical Record*, Dec. 17, 1877. 11 pp.

A Study of the Causes and Treatment of Uterine Displacements. By Thomas Addis Emmet, M.D, New York. From Volume xii, *Gynecological Transactions*, 1887. 14 pp.

—Dr. Stickler's paper deals with a subject of the greatest interest and importance. It contains an admirable description of foot and mouth disease in human beings and in the lower animals of the equine and bovine species, and a very interesting study of its relation to scarlet fever. The chief interest and value of the paper lie in his study of the relation of this disease to scarlatina. The conclusion to which he comes, and which he states with praiseworthy reserve, is that foot and mouth disease and scarlet fever are so related that the inoculation of human beings with the virus of mild aphthous fever in cattle may serve as a prophylactic against scarlet fever. This conclusion and Dr. Stickler's reasons for it may well be recommended to the consideration of our readers, who will find food for much thought in his interesting paper, to which we have already referred in an editorial in the Reporter for Feb. 4, 1888.

—In this pamphlet, Dr. Ashby gives the history of two cases in which miscarriage attributed to syphilis was followed by prolonged and stubborn sub-involution of the womb, and metrorrhagia. These he thinks were also attributable to syphilis. He does not assert this dogmatically; but says he has never seen any cases so difficult to manage, and can find no explanation of the fact more reasonable than the one he proposes. Other observers may have had similar experiences, to which this explanation would not apply; but Dr. Ashby's paper deserves consideration and may throw an important light upon an obscure subject.

—Dr. Meriam is a dentist who was graduated at the Harvard University Dental School, and who thinks dentists should be more than mere artisans; and he endeavors in this pamphlet, which contains an address he delivered before the Maine Dental Society, at its 22d annual meeting, in July, 1887, to impress his fellow-practitioners with the importance of observing a system of ethics like that established for the medical profession. He is especially opposed to the practice of patenting instruments or appliances, and of permitting what should be the common property of all who are engaged in the healing art to come under the exclusive control of manufacturing firms. These views, which must commend themselves to the judgment and sentiment of those who regard dentistry as a profession, he supports with argument and pleasantry, which make his address as entertaining as it is instructive.

—Dr. Craig's pamphlet contains a variety of short communications on medical subjects, several of which have appeared in the Reporter. One of the most interesting of these concerns a case of precocious menstruation. The subject was a child who began to menstruate when only four years of age, and continued to menstruate regularly until she was ten years old, when she ceased menstruating until she was fourteen years old, and then began again.

Another communication brings forward a claim for priority in the use of an elastic rubber band for ligating the umbilical cord, which the author recommended before the Medical Society of New Jersey in 1870.

—Dr. Oliver's short paper gives the results of the examination of the eyes of twenty young adult imbeciles. His conclusion is that the eyes of such persons show the effect of intellectual hebetude in the absence of changes frequently found in those who use the eyes constantly.

—Dr. Gleitsmann's paper contains an account of the case of a man who had a hæmatoma of the larynx as a consequence of a blow upon it with the fist of an assailant. In addition to the interest attaching to this case in connection with the general subject of laryngology, it is curious to note that the blow caused temporary insensibility, confirming the recent experimental demonstration of Brown-Séquard that such a result may follow such a cause.

—Some of our readers may be surprised at the term "tonsil of the tongue," as the word "tonsil" is usually applied to what anatomists call the "faucial tonsil;" and they will be interested to learn that aggregations of glandular tissue exist at the base of the tongue, which are but part of a ring of glandular tissue surrounding the opening of the mouth into the pharynx. These masses may become hypertrophied, just as what are usually known as the tonsils do, and when this happens they are to be treated by reduction or destruction of the redundant tissue. For the details of this treatment we must refer our readers to Dr. Gleitsmann's interesting and instructive paper.

—Dr. Emmet's paper ought to be read by every man who wishes to treat displacements of the uterus rationally. His large experience gives great weight

to what he says, and those who have treated cases of the kind he discusses must share, to a certain extent at least, his strong objection to the indiscriminate use of pessaries. He sees plainly that it will be hard to wean men from a practice which has the sanction of so much authority and experience, but he brings forward reasons for its restriction which appeal strongly to the judgment, and which ought to be weighed most carefully by those least inclined to accept them.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The *Caledonia Springs Sanitarian*, published at Caledonia Springs, Ontario, once a month, four pages, quarto, price ten cents a year, is the lowest priced semi-medical periodical we have seen yet. Its appreciation of the Reporter is seen in the fact that it looks to this journal for assistance in editing it. We observe, for example, in Vol. II, No. 2, January, 1888, one of our recent editorials on "Some Points in the Care of Children;" but we are pained to observe that the printer has cut out the reference to the source from which it was taken, which we feel sure the editor of the *Caledonia Springs Sanitarian* must have been careful to put in.

—The *Cyclopedia of American Contemporary Biography*, "from Abbe to Anderson," is received from John B. Alden, New York. It includes notices of men and women of the United States, prominent in the life of to-day. It is to be issued in small 8vo volumes of about 550 pages each, brevier type, including numerous portraits, and is to be revised and re-issued as often as annually. Volumes bound in fine cloth, price $1.00, postage 12 cents. The specimen we have received is interesting, and promises well for the whole work. We remark the absence of the names of a number of distinguished medical men in this city, which ought to have been included in a work making any pretension to completeness; but, as far as it goes, the list is useful.

—The attention of persons interested in historical or scientific investigations, or in the making of books of substantial character, is invited to the proposals of *The Editorial Research Company*, of Philadelphia, which is composed of persons who have had many years' editorial experience, and who are convinced of the need of such an agency as they have established. This company offers its assistance to persons engaged in literary work, in making researches, gathering statistics, making transcripts or translations, correcting manuscripts, and preparing indexes or reviews. Persons desiring further information as to the purposes of the company may address *J. P. Lamberton, Secretary*, 721 South Sixteenth street, Philadelphia.

—The J. B. Lippincott Company announces the intended publication of a *Cyclopædia of Diseases of Children*, to be edited by John M. Keating, M.D., of Philadelphia. The list of contributors, who have agreed to share in the preparation of this work, includes the names of a large number of well known writers in this country and in England, and justifies the expectation that it will be a work of very great value.

Correspondence.

Sudden Death After Typhoid Fever.

Editor Med. and Surg. Reporter:

Sir:—On January 11, 1888, I was called to see a young man, 17 years old, who was suffering with an attack of typhoid fever. I attended him regularly for twenty-four days, when he died suddenly and unexpectedly, having presented no unfavorable symptoms until within a few hours before his death. At the beginning of his illness his temperature rose gradually until, on the eighth day of the disease, it was 103°. After this it fell gradually until, on the twenty-fourth day, it was 102½°. At this time his tongue and the surface of his body were moist, and his pulse was about 90–95, and full and strong. He had some headache during the first few days, as is usual in typhoid fever, but was perfectly rational up to the time of his death. He had no diarrhœa at any time; neither was he constipated to any marked degree. Castor oil was administered two or three times with gently purgative effect. His bowels moved three days before his death. He had no trouble, which was discoverable, with his urinary organs, his urine being voided freely and in quite sufficient quantity. He never had any extensive tympanites, or excessive tenderness over the bowels, but was troubled somewhat more than is common with pain, though this was generally controlled with warm fomentations. Opiates were resorted to only a few times. He had no trouble with his lungs, except a very slight bronchitis, which was not as marked as is usual in this disease. His tongue was heavily coated for the first ten days, when it began to clean off. The only thing in its appearance, which I did not like, was the fact that the papillæ seemed to be rather prominent, and that the color was a slight shade redder than is usual in mild cases. The surface never became very dry. He took milk every day in sufficient quantities. In fact, he progressed favorably up to the twenty-fourth day, at noon, when I visited him.

I had given a favorable prognosis all along, and could not see anything in his case which should cause me to do otherwise. But at about 11 or 12 o'clock at night, he began to be restless and short of breath, while his pulse became quick, and remained so all night. The next morning (the twenty-fifth day), at 8 o'clock, I was called to see him, and to my great astonishment I found him with a pulse of 150, the first sound of the heart inaudible, with great distress in his breathing, a very

anxious expression, and an appearance of being in pain. When asked if he were suffering pain, he said: "No, not of any consequence." I at once recognized his great danger; but was at a loss to account for it. My first impression was that perforation of the bowels had taken place. But finding no vomiting, no more tympanites, no more pain, no more fever, and the patient able to move himself without pain, and other symptoms of perforation being absent, I concluded that it must be a case of sudden heart failure, and so expressed myself. As I have already said, he was never irrational, even to the last.

My experience with typhoid fever dates back nine years, and I have treated cases every year; but this case was different from any I have ever seen. I would be pleased to have an expression from you, or from any of your readers, as to the immediate cause of death. Yours truly,

S. M. HUNTER, M.D.

Hope, Kansas.
February 1, 1888.

[The facts stated in this letter do not warrant any positive expression of opinion; but the explanation offered by Dr. Hunter, as to the *immediate* cause of death, seems to be entirely rational.—EDITOR OF REPORTER.]

Sulphate of Magnesia for Warts.

EDITOR MED. AND SURG. REPORTER:

Sir:—*Apropos* of recent statements as to the efficacy of sulphate of magnesia in the treatment of warts, I would like to mention the following case which recently came under my notice: A man consulted me respecting a growth of vegetations surrounding the glans penis, forming a huge mass, almost as large as a hen's egg. I prescribed the use of a powder of equal parts of salicylic acid, calomel and oleate of zinc, to be renewed night and morning. The case improved slowly, too slowly for the patient's satisfaction. I then ordered one grain of sulphate of magnesia every hour, in solution, in addition to the application of the powder already mentioned. The growths now commenced to disappear rapidly, and in less than three weeks there was not a vestige of them left. The patient states that they mysteriously "melted away." He used the magnesia regularly, every hour of the day for the first week, but became more careless for the rest of the time. Yours truly,

LOUIS LEWIS, M.D.

800 Corinthian Avenue, Philadelphia.
Feb. 4, 1888.

Correction.

EDITOR MED. AND SURG. REPORTER:

Sir:—In my article on *Diphtheria, January 28, 1888*, page 100, the direction for gargle should read: "*Gargle well every two hours*, OR *ten minutes each time before taking the medicine.*" The direction in the second spray should read: "*Spray each time before giving the medicine, and apply a cloth dipped in cold vinegar*, not too wet, to the neck." Further down read: "*Elix. phosphate iron quinia and strychnia with liquor potassæ arsenitis.*" In the last formula read: "*I order syr. ferri iodidi and liquor potassæ arsenitis to be taken after meals.*"

I think a great deal of all arsenical preparations in cases of debility, as well as in all chronic affections.

Yours truly, J. PIRNAT.

Evansville, Ind.
Feb. 2, 1888.

Koumiss and Lupulin.

EDITOR MED. AND SURG. REPORTER:

Sir:—In the present volume of the REPORTER, page 125, you copied from the *National Druggist* directions for making koumiss. I would suggest the addition of one teaspoonful of *lupulin*. I have been accustomed to make the addition in several of those fermentative mixtures where there is considerable nervousness of the patient. It will be found soothing and exhilarating.

JOHN M. CURRIER, M.D.

Newport, Vt.
Feb. 6, 1888.

Masturbation in Women and Girls.

EDITOR MED. AND SURG. REPORTER:

Sir:—I was glad to see the article in your columns entitled "Masturbation among Women and Girls." This is a delicate subject to treat, but it surely comes within the province of a medical journal. I believe that the vice to which you allude is not so common as many people suppose. At the same time, its frequency in ancient and modern times among women of indolent, luxurious and voluptuous habits is unquestioned. Here, heredity, high living, and artificial and precocious stimulation of the sexual appetite are, as you have intimated, powerful factors in bringing about the practice of this vice. It is hard to believe that the "gentler," "purer" sex can become so depraved; but it is not to be expected that the daughters will be much more virtuous than their fathers, and shameless women are not a rare phenomena even

in this Christian land. You speak of the preponderant influence of the sexual passion in the thoughts, imaginations and lives of multitudes—a fact for proof of which your readers will not have to go far. As for the allusion to the popularity of certain filthy French novels, it is gratifying to be able to chronicle the fact that the worst kind of French romances have not been reproduced, and cannot be reproduced in this country or in England.

I have personally seen comparatively little evidence of masturbation, though occasional instances are constantly coming under my observation. I fancy that most physicians hesitate, like myself, to interrogate their female patients with regard to these practices, though they may often have reason to suspect that such practices exist. Glaring instances will, however, now and then present themselves where complete physical and moral ruin has resulted from the unnatural indulgence. One such instance I saw some years ago, in which the beginning of the vicious habit could be clearly traced to the manipulations of a servant girl. Another girl, 13 years old, the daughter of a clergyman, seemed to have contracted the habit from "pure cussedness," and was one of the most remarkable instances of "innate depravity" that I have ever seen. In her case the habit was most inveterate, beginning at the age of six years; and no amount of moral suasion or correction, and no punishment availed to stop the pernicious habit altogether. Even when this girl was put in a straight-jacket and watched day and night, she found some means of exciting the sexual orgasm, and bringing about the abominable gratification. For aught I know, this patient, who is now grown to womanhood, is in daily practice of the habit. The mind has been enfeebled and the body dwarfed—in fact, this unfortunate being is a perfect nonentity as far as concerns her relations to her family and to society.

Another young girl, 7 years old, a patient of Dr. Healey, was broken down physically and mentally by the vice, and is to-day an inmate of the insane asylum at Danvers, Mass. Dr. Healey, moreover, tells me that he has at the present time under his care a female infant, only 2 years of age, who is a confirmed masturbator.

Such instances might be multiplied from the experience of many of your readers. The inveterate female masturbator is generally a hopeless case. Much can doubtless be done by every intelligent physician in inculcating among his patrons a knowledge of the existence of the vice and its dangers, and insisting upon the proper hygenic means of prevention, so that no undue awakening may be given to an appetite which nature intended should slumber till maturity; which even then ought to be very sparingly indulged, and by many persons, I think, never at all. It is not alone the appetite for strong drink that requires regulating, if not suppressing.

E. P. HURD, M.D.

Newburyport, Mass.,
Feb. 6, 1888.

NOTES AND COMMENTS.

Dizziness from Injuries to the Tympanum.

Dr. A. D. Williams reports in the *St. Louis Med. and Surg. Journal*, January, 1888, that a young man recently received a severe blow upon the left ear from a wagon stake, and was knocked senseless for a while. The ear bled freely at the time, and after recovering from the headache and the immediate effects of the blow, the patient found that he had difficulty in hearing with the ear which had been injured, and complained of a sense of numbness, or a "muffled feeling" therein. The history of the case showed plainly that there had been a rupture of the membrana tympani, but when Dr. Williams examined the ear, two weeks after the injury, there was no sign of a rent, the injury having healed so perfectly that he could not even discover its previous location. The patient, however, was so dizzy at the time that he could not walk straight, and staggered about like a drunken man. The cavity had evidently filled with blood at the time of the injury. He catheterized the drum, and found it very difficult to get the air into the cavity. The operation gave great relief to the patient, but it lasted for only a few minutes. While there might have been other injuries inflicted by the blow in this case, the author thinks the dizziness resulted entirely from the obstructed condition of the drum. In a recent case a similar phenomenon was observed. A young woman slipped and fell, striking the side of her head flat against the pavement. She at once noticed that her hearing was muddled, and that the ear on which she fell "felt as though it had been stuffed full of something," to quote her own words. On attempting to stand, she found herself so dizzy that she was compelled to catch hold of something to support her. Twelve hours after the injury he made an examination, and found a bloody line just behind the handle of the malleus, and running its entire length, showing that the

rupture of the membrane was an extensive one. While the ear did not bleed any externally, the cavity was most likely filled with blood. As the injury was still fresh, and the rupture was nicely coapted but not yet healed, he thought it best not to interfere at the time, but told the patient to return later, which she has not yet done. The cases are given to illustrate the point which the author has made before, that great dizziness frequently results from the filling up of the drum cavities, and that, in fact, very grave brain symptoms are frequently traceable to this cause, especially in childhood.

Laparotomy for Incised Wound of the Stomach; Recovery.

Dr. J. A. Black, M.D., reports the following case in *Daniel's Texas Medical Journal*, December, 1887: William Edwards, 17 years old, was stabbed, while attending a country dance, on July 20, 1887, at 9 o'clock P.M. The long blade of a large pocket knife entered the abdomen at the left side, immediately below the lower margin of the ribs, about five inches from the median line, making an external wound two inches long, which extended toward the median line, and parallel with the margin of the ribs. From this wound undigested food and blood escaped.

On July 21, at 9 o'clock A.M., twelve hours from the time of the injury, Dr. Black saw the patient for the first time. He had tossed about all night in great pain, and without medical attention. He was given anodynes and placed in a position which favored the escape of the food and blood until assistance could arrive. Four hours later, Dr. Black and Dr. T. J. Bennett, of Austin, proceeded to operate by enlarging the original cut in the direction of the median line. First an incision about two inches in length was made, which, proving to be inadequate, a further incision was carried to the median line, making a total external opening of five and a half inches transversely across the abdomen, terminating just below the xyphoid cartilage. Several large fish bones, some of them over an inch in length, and a quarter of an inch in diameter, together with a quantity of undigested food, and some blood, were found lying on the great omentum and intestines, and were removed. The small intestines, as well as the transverse and a portion of the descending colon, were pulled outside, laid upon aseptic towels, and searched for wounds, but none were found. The investigation was extended above the line of incision, when it was found that the blade had passed through the great omentum and entered the stomach near the center of the great curvature, making a wound about one and a half inches in length. The stomach was then drawn outside, and two interrupted and two continuous sutures, making four in all, were made in the wound. Fine iron-dyed silk was used to close the wound. Catgut was thought of, but it was feared that the gastric juices would digest the sutures before union could take place. As the stomach was pulled outside vomiting took place, and some depression was noticeable for a short time. It is worthy of note, that, while vomiting was taking place, the stomach was held in the hand of the operator, and the firm and uniform contractions, which the muscular structure of the stomach would indicate should take place in vomiting, were actually felt. Absorbent cotton was used instead of sponges. The viscera were carefully cleansed and returned, and the abdominal cavity mopped out with the cotton. No irrigation was employed. The external wound was then closed by eight interrupted sutures of strong iron-dyed silk, the peritoneum being included in each one. Space was left for the escape of pus, in case any should form. Iodoform and carbolated absorbent cotton, confined by a broad bandage, tightly applied, constituted the dressing. The patient was placed on his back, with the shoulders elevated, and a roll of quilt placed under the knees. Anodyne and nutrient enemas were ordered, and only ice water was allowed to enter the stomach. The position of the patient, and attention to the bladder, etc., constituted the chief directions given the nurse after operation. Although the external wound suppurated and the patient was subsequently attacked with colliquative diarrhœa, so severe as to threaten life, he ultimately made a complete recovery.

An English View of Homœopathy.

The *British Medical Journal*, referring to some recent statements by Lord Grimthorpe, remarks that the latter has a boisterous rhetoric, and wields the literary truncheon with quite a special gusto. He is not infrequently, and always noisily, at fault; and rarely more so than in his present assault on medical men who decline professional association with homœopaths. In the main he strikes wide of the mark. No one pretends that "homœopathic" practice is illegal, any more than "magnetic" practice, or "faith-healing." But homœopathy, in the opinion of medical men generally, is either a nullity or a fraud. Under this conviction, which is shared by

the wisest and the best among us, medical men habitually decline to consult or to act professionally in concert with "homœopaths." This Lord Grimthorpe decribes as "boycotting." If so, it is only a new name for a very old practice, which the bar, equally with the profession of medicine, have found necessary to maintain a due standard of professional sense and morality. If a barrister were to see clients and receive instructions without the intervention of a solicitor (a purely artificial restriction), what course would his professional fellows and the class of solicitors adopt? The professional etiquette and the rules of the practice at the bar are in many ways more restrictive than those of the profession of medicine and more severely enforced. Everyone who pleases is free to practice "homœopathy," or any other "pathy" he can practice in this country with or without education, and with or without a degree. A penalty is incurred only on the false assumption of a title. It is open to Lord Grimthorpe or to anyone else to consult him or to build hospitals for him to practice in. But it is certainly not in his power or his right to constrain the great body of highly educated men who regard such practices as frauds, or nullities, or public dangers, to enter into or to countenance any professional alliance with their professors. His violence, his threats, and his rhetoric appear, therefore, to be alike thrown away.

Treatment of Carotid Hemorrhage.

Mr. Frederick Treves, surgeon to the London Hospital, in a communication upon the treatment of carotid hemorrhage to the *Lancet*, Jan. 21, 1888, remarks that he thinks the ligature of main arteries for the arrest of bleeding in distant parts is often somewhat blindly advised, and possibly too frequently carried out. He reports four cases in which, instead of tying the artery, he passed a ligature around the common carotid, and kept up traction upon the ligature for some time after the hemorrhage ceased. The method proved satisfactory in every case. One patient, a child three years old, died six days after the operation, but death was the result of exhaustion from previous hemorrhage. The hemorrhage was in all four cases of a grave character, and such as, in three of the instances, one who adhered to the usual surgical practice would have controlled by means of ligature of the common or external carotid. By the exercise of careful antiseptic precautions, he thinks that no very serious risks attend the operation itself.

The Medical Societies of Brooklyn.

There are no less than six different societies in Brooklyn organized and maintained for the advancement of medical science. Some of these bear in their titles the name of the county rather than that of the city; but their membership is made up mainly of residents of Brooklyn, which city is in fact the greater part of the County of Kings in respect to population. These societies are: the Medical Society of the County of Kings, the Brooklyn Pathological Society, the Medical Microscopical Society of the City of Brooklyn, the Brooklyn Surgical Society, the Kings County Pharmaceutical Society, and the Brooklyn Dental Society.—*Brooklyn Medical Journal*, January, 1888.

A Doctor Classed as a Commercial Traveller.

The Paris correspondent of the *New York Medical Journal*, February 4, 1888, says: Another case of professional interest was decided by the Paris tribunals lately. A doctor had agreed with a druggist to write articles recommending a certain chemical product manufactured by the druggist, and also to deliver lectures in regard to the product, recommending it, in fact, by all possible means to his professional brethren and the public. In consideration of these services the druggist agreed to pay the doctor 4000 francs a year and certain expenses. Afterward the doctor refused to continue the work for the druggist, who at once sued him. The doctor's lawyer maintained that he could not be compelled to carry out such a contract, as he was not a man of business. The tribunal, however, decided that, as the doctor had agreed to do work such as an ordinary commercial traveller did, he was responsible. It was added that a physician should only advise any preparation which he knew to be useful in the ordinary way of giving advice at his office or at a patient's house, and not by advertisements; and that he should not receive any payment for such advice, beyond his usual professional fees, under pain of being ranged with the regular mercantile traveller. This would not be a bad judgment on those who recommend certain preparations, for a consideration, in other countries!

Successful Excision of a Tumor of the Spinal Cord.

At a meeting of the Royal Medical and Chirurgical Society on Tuesday, January 24, 1888, Mr. Victor Horsley presented the patient from whom he had removed a myxoma

of the spinal cord on June 9, 1887 (see REPORTER, July 23, p. 126, 1887). It is interesting to learn that, following the operation, the pain from which the patient had suffered acutely was for a time slightly relieved, but again and again recurred with great severity, and the power of motion was only slowly and intermittently regained during the first three or four weeks. Pressure over the wound was obtained by a pad and strong jacket; the local pain gradually diminished; the motor power gradually returned to the lower parts; and, after seven months, the use of the lower limbs, though a little stiff, had become almost natural, and the remains of the laminæ had come so near together in the well healed cicatrix that any further external support seemed unnecessary.

Charges against an Eclectic Physician.

A despatch from Chicago to the New York *World*, January 20, says: A. B. Pullman, brother of George M. Pullman, of the Pullman Palace Car Company, has begun a suit for $25,000 damages, charging criminal malpractice against Dr. Pingree, an eye and ear specialist, for whom it is understood a warrant is out. Mr. Pullman's wife has had a cancer on the nose for about ten years, and it has eaten away the greater part of that organ, greatly disfiguring her face and endangering her life. Dr. Pingree has been treating it for the last two years, and Mr. Pullman alleges that he used violent remedies which made the cancer worse. Dr. Pingree was graduated at the Bennett College of Eclectic Medicine and Surgery, Chicago, in 1880.

Prescription for Chronic Cystitis.

Prof. Brinton recommends (*College and Clinical Record*, January, 1888), for chronic cystitis:

℞ Uvæ ursæ..... ..... ℥ij
Lupulini..... ..... gr. xv
Aquæ bullient..... f℥vj
Misce. Ft. infus. et adde
Sodii bicarb..... ℥ss
Tinct. opii camph..... f℥j
Aquæ..... q. s. ad f℥viij.
M. Sig.—Tablespoonful four times a day.

Ointment in Small-pox.

The following ointment is said to act as an anæsthetic and antiseptic, and to prevent pitting:

℞ Pulv. iodoformi..... ℥ss
Pulv. camphoræ..... ℥i
Vaselini puri..... ℥j
Misce. Ft. ung. Sig.—Apply by gentle inunction to the affected parts of the skin.

NEWS.

—Dr. Harvey Shoemaker and Dr. Thompson S. Westcott have been elected resident physicians of the Pennsylvania Hospital in its Insane Department.

—Recent reports from San Remo regarding the condition of the Crown Prince of Germany are rather unfavorable, and it has been found necessary to perform tracheotomy earlier than was at first expected, in order to relieve the difficulty in breathing.

—It is reported from Springfield, Illinois, that scarlet fever is prevailing in Pana, on the Ohio and Mississippi Railroad, to such an extent that the public schools have been closed. There have been two deaths, and fifteen cases of the disease were reported on February 4.

—The committee of the New York Academy of Medicine, appointed to coöperate with the Health Board of that city, has made its report to Mayor Hewitt. The committee consisted of Drs. C. R. Agnew, E. C. Janeway, Stephen Smith, A. Jacobi, T. Mitchell Prudden, H. M. Briggs, and Richard H. Derby. The Mayor requested the committee to make an early examination of the Quarantine establishment, point out its defects and requirements, in order that it may be brought up to the highest ideal standard of modern scientific and medical knowledge, to estimate the sum required to be appropriated by the state in order to complete the necessary improvements, and to suggest whether New York should provide any further temporary hospitals in case there should be an outbreak of cholera in the city.

The character of the report is such as to excite concern in New York in reference to the miserable condition of things at Quarantine. The *Tribune* says, Jan. 3, 1888, "So long as it continues the entire country is confronted with an appalling danger. When such an able committee as that which presents this report unites in confirming in detail all that the public has long feared with regard to Hoffman Island, it is high time for action. The medical committee has performed its work with commendable completeness. It shows what must be done and just how to do it. The Legislature will doubtless be its own best judge of how the suggested commission should be composed, but the evidence now before it of the necessity of providing the island with adequate facilities for holding imported contagion in check is too abundant and too serious to be disregarded."

HUMOR.

A GEORGIA FARMER made one hunderd dollars off an acre planted in watermelons, and a neighboring doctor made two hundred dollars off the same acre.

FAITH CURE AND PHYSIC.—Gus De Smith—"I've been reading about a remarkable faith cure." Gilhooly—"I don't believe in it. Physic beats the faith cure every time." Gus De Smith—"Well, it ought to; it has the inside track."

A FORMER PATIENT met a doctor who practiced at a mineral spring, in Germany, and said to him: "Why, doctor, if you are a physician to the springs, how comes it that I find you in Frankfort?" "Well," replied the doctor, "you see I am a physician to the springs in summer; in winter I collect patients."

LADY (handing prescription ordering pil. aloes et ferri gr. vj; mitte iv): "Make up this prescription, please. How much will they be?"

Chemist: "Sixpence."

Lady (astonished): "Oh! dear, no! they will be more than that; *that is one of Sir William Gull's prescriptions.—Chemist and Druggist.*

A YOUNG PHYSICIAN, who has just established himself, and has very little practice, is noted for his braggadocio. One of the older physicians, meeting him on the street yesterday, asked him how he was coming on. "I've got more than I can attend to," was the boastful reply; "I had to get out of my bed five times last night." "Why don't you buy some insect powder?" asked the old doctor.

NEW USE FOR ICE.—"I'm going to Maine after a consignment of ice for consumption in Washington," said an Avenue dealer to a new reporter nosing around for an item.

"Indeed," exclaimed the reporter, pulling his note-book, "that's something new. I didn't know before that ice was a remedy for consumption."

The city editor saved the reputation of the paper.—*Washington Critic.*

OBITUARY.

E. MILES WILLETT, M.D.

Dr. E. Miles Willett, Professor of Clinical Medicine in the Memphis Hospital Medical College, and Supreme Medical Examiner, Catholic Knights of America, died suddenly on February 6, 1888, at his residence, in Memphis, Tenn. He was graduated at Jefferson Medical College in 1855.

GEORGE W. TRYON, JR.

Mr. George W. Tryon, Jr., who died on February 5, 1888, at the age of 50 years, was the most eminent conchologist in this country, if not in the world, and a highly valued member of the Academy of Natural Sciences.

WILLIAM ASHMEAD, M.D.

Dr. William Ashmead died at his home in Germantown on February 2, 1888, aged 87 years. He had been a practicing physician in Philadelphia for upwards of fifty years; but, about ten years ago, he withdrew from active service and retired to his home in Germantown. He was connected with the State and County medical societies, and took considerable interest in other professional and scientific associations. One of his most recent acts of benevolence was the contribution of $3000 to the Wills Eye Hospital.

E. J. SNITCHER, M.D.

Dr. E. J. Snitcher, a well-known physician of Camden, N. J., died on February 6, 1888, in his 39th year. He commenced the study of medicine in the office of Dr. N. S. Davis, of Chicago, in 1872. In March, 1874, he was graduated from the Chicago Medical College, and subsequently removed to Camden. In 1876 he became a member of the Camden County and the New Jersey State Medical Societies. He was a director of the Camden City Dispensary until impaired health made it necessary for him to retire.

E. J. ENGLEMAN, M.D.

Dr. Edgar J. Engleman, a well-known physician, died on Monday, February 6, 1888, at his residence in Philadelphia, at the age of 74 years. He was graduated at the Jefferson Medical College over fifty years ago, and practiced his profession for a number of years in the West. Until recently, he lived at No. 701 Pine Street.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Feb. 5, 1888, to Feb. 11, 1888:

Major John H. Janeway, Surgeon; Capt. William E. Hopkins, Assistant Surgeon, detailed as members of the Army Retiring Board in San Francisco, Cal.; convened by S. O. 168, A. G. O., July 22, 1886. S. O. 28, A. G. O., Feb. 4, 1888.

First Lieutenant Nathan S. Jarvis, Assistant Surgeon, ordered from Fort Lewis, Col., to Fort Leavenworth, Kansas. S. O. 30, A. G. O., Feb. 7, 1888.